

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Tarban papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00649														
CERTIFICATE OF DEATH										00649														
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
James Monroe Austin										Month Day Year					8:30 am									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years lost birth day)									
Male					White					1-1-77 ?					52 YRS.									
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH									
USA, Iowa					U.S.A.										Carroll Co. Md.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY									
Sykesville, Md.					Springfield State Hospital					Butcher														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. CITY OR TOWN					13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13d. STREET AND NUMBER									
Maryland					Montg. Co. Gaithersburg										Box 445									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
William Austin					Jenney										? ?									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address									
Yes					World War I					265-22-9749					Hospital Records									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>										days														
DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) <u>Generalized arteriosclerosis</u> years														
DUE TO, OR AS A CONSEQUENCE OF																								
(c) <u>Arteriosclerotic heart disease</u>										years														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																								
CBS associated with cerebral arteriosclerosis with psychotic reaction																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (X) (this hospital) attended the deceased from <u>5-18-</u> , 19 <u>65</u> , to <u>1-11-</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>01/11/</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE										22c. DATE SIGNED														
Moises Sucholeiki, M.D.										1-11-69														
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS														
Moises Sucholeiki, M. D.										Springfield State Hospital, Sykes, Md.														
23a. BURIAL CREMATION, REMOVA (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
(REMOVAL)					1-14-69					ANAT. GUARD U. of MD.					BALTIMORE, MD.									
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE				
David Funeral Home										16 1969										Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A M
THEODORE			(NMN)	BAMBERGER		JANUARY 24, 1969			5:40
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		7-20-08		60		YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Carroll Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Sykesville			Springfield State Hospital			Machine Operator			Meat Co.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore City		Baltimore				3112 Keswick Rd.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Henry			Bamberger			Frances			Lipki
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
National Guard			217-09-2995			Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 4-22-68, 19__, to 1-24-69, 19__, that (I) (we) last saw the deceased alive on 1-24-69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Octavio A. Ruiz M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-24-69	
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.						22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-27-1969		Oak Lawn Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George J. Gonce, 4001 Ritchie Hwy., Baltimore						DATE JAN 29 1969		Charles Judge	

24300

1961-1962

1961-1962

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

3. The third part is a summary of the work done during the year.

4. The fourth part is a summary of the work done during the year.

5. The fifth part is a summary of the work done during the year.

6. The sixth part is a summary of the work done during the year.

7. The seventh part is a summary of the work done during the year.

8. The eighth part is a summary of the work done during the year.

9. The ninth part is a summary of the work done during the year.

10. The tenth part is a summary of the work done during the year.

11. The eleventh part is a summary of the work done during the year.

12. The twelfth part is a summary of the work done during the year.

13. The thirteenth part is a summary of the work done during the year.

14. The fourteenth part is a summary of the work done during the year.

15. The fifteenth part is a summary of the work done during the year.

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VR 1-1-68
30M REV. 11-68

00651

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00646

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
CHARLES			B.		BARNES	Month Day Year 1 13 69			5 ¹⁰ P ^M		
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male	White		Aug. 20, 1893			75 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Carroll Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		Carroll Co. Gen. Hospital				Carpenter-retired					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Carroll		Finksburg				R.D. 2			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Lloyd			G.		Barnes	Ida					Williams
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name and rank) (If yes, give year and dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Yes		WW I		213-18-8802		Mrs. Kathryn A. Barnes Same As #13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4/123</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>YEARS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>PULMONARY EMPHYSEMA</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>12/28, 1968</u> , to <u>1/13, 1969</u> , that (I) (we) last saw the deceased alive on <u>1/13, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Vincent J. Fiocco</u>						22c. DATE SIGNED <u>1/13/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>Vincent J. Fiocco</u>						22e. ADDRESS <u>Westminster, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		1-16-1969		Mt. Pleasant Cemetery		Gamber		Carroll		Md.	
24. FUNERAL DIRECTOR <u>C. M. Waltz, Box 241, Sykesville, Md.</u>						25a. REC'D BY REGISTRAR <u>JAN 16 1969</u>		25b. SIGNATURE <u>[Signature]</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) RHODA ANNA BARNES						2a. DATE OF DEATH Month JAN Day 20 Year 69			2b. HOUR 12:05 PM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH NOV. 18, 1894		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS 7 DAYS 14		IF UNDER 24 HRS. HOURS 12 MIN. 05	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL CO. Md.					
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO. GEN. HOSP. CLERK, TELEPHONE CO.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 70 W. GREEN ST.			
14. FATHER'S NAME First WILLIAM ODEN BARNES Middle MARGARET N. RIDINGER Last MARGARET N. RIDINGER				15. MOTHER'S MAIDEN NAME First MARGARET N. RIDINGER Middle MARGARET N. RIDINGER Last MARGARET N. RIDINGER				Address 1461ST ROAD WESTMINSTER MD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 212-10-0032-A		17. INFORMANT J. CAROLD BARNES					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral ischemia DUE TO, OR AS A CONSEQUENCE OF (b) Hypotension DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial Infarction.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10-15 min 1 hr. 1-24 hr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic obesity											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from April , 19 68 , to Jan 20 , 19 69 , that (I) (we) last saw the deceased alive on Jan 20 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.											
22b. SIGNATURE William R. Rourke MD DEGREE MD						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Jan 20/69			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/23/69		23c. NAME OF CEMETERY OR CREMATORY BETHEL CEMETERY		23d. LOCATION (City or Town) R.D. (County) (State) NEW WINDSOR, CARROLL MD					
24. FUNERAL DIRECTOR E.S. Murre Jr. Westminster, Md						25a. REC'D BY REGISTRAR JAN 22 1969		25b. REGISTRAR'S SIGNATURE William R. Rourke			

PERMANENT WHITE
REMOVED WITH
WATER
WILLIAM ODEE BARNES
312-10-10551-1 BARNES BARNES WITH

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11-21-10 BARNES BARNES
BARNES BARNES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 15 4
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
Pearl			V. Becraft			Month 1 Day 24 Year 69		8 a M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		Aug. 25, 1897		71 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Carroll Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Woodbine			Box 25			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Carroll		Woodbine		X		Box 25	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
George A. Green			Margaret Hatfield							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			215-20-7784		Norman A. Becraft, Sr. Same As #13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent coronary occlusion 4100 DUE TO, OR AS A CONSEQUENCE OF presented as Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarction of myocardium: pulmonary edema 2 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive ASCVD 10 yrs.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Heart failure, Diabetes mellitus										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Oct. 13, 1966, to Jan. 24, 1969, that (I) (we) last saw the deceased alive on Aug. 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Sani Okutman, M.D.					22c. DATE SIGNED 1/24/69					
22d. PHYSICIAN'S NAME (Type) Sani Okutman, M.D.					22e. ADDRESS Obrecht Rd., Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		1/27/1969		Lakeview Memorial Gardens		Carroll Co., Md.				
24. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Box 241, Sykesville, Md.					25a. REC'D BY REGISTRAR DATE JAN 28 1969		25b. REGISTRAR'S SIGNATURE			

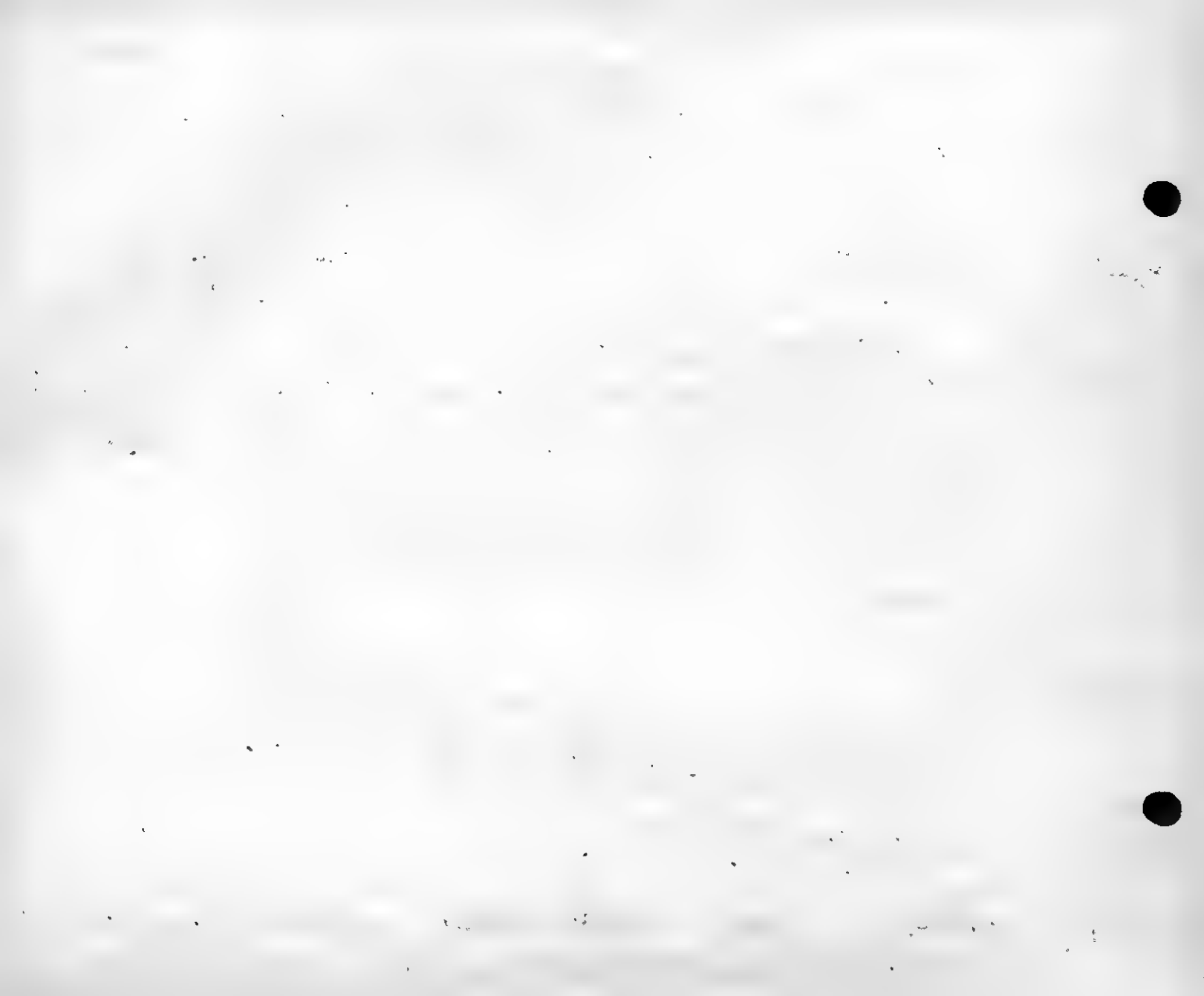
RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C. 20250
OFFICE OF THE SECRETARY
ATTENTION: ASSISTANT SECRETARY FOR
GENERAL AFFAIRS
MAIL ROOM
MAIL STOP 1000
WASHINGTON, D.C. 20250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last JAMES CLAYTON BLOOM			2a. DATE OF DEATH Month Day Year JAN 3 1969			2b. HOUR 6:45 P	
3. SEX MALE		4. RACE white		5. DATE OF BIRTH June 5, 1884		6. AGE (in years last birthday) 84 YRS.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.	
10. CITY OR TOWN OF DEATH Uniontown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Westminster		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Construction foreman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD.		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 85 W. Main St.							
14. FATHER'S NAME First Middle Last Granville Bloom			15. MOTHER'S MAIDEN NAME First Middle Last MARY WEBSTER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 214-01-0666		17. INFORMANT Raymond Bloom Jr. Uniontown Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Bladder (Transitional Cell) 188X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 4, 1966 to JAN 2, 1969 , that (I) (we) last saw the deceased alive on Dec 15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dean H. Griffin M.D.				22c. DATE SIGNED 3 JAN 69			
22d. PHYSICIAN'S NAME (Type) DEAN H. GRIFFIN, M.D.				22e. ADDRESS 12 Ridge Rd. Westminster Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/6/68		23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH		23d. LOCATION (City or Town) (County) (State) WESTMINSTER CARROLL MD	
24. FUNERAL DIRECTOR J. S. Myers Jr. Westminster, Md.				25a. REC'D BY REGISTRAR JAN 7 1969		25b. REGISTRAR'S SIGNATURE James Judge	

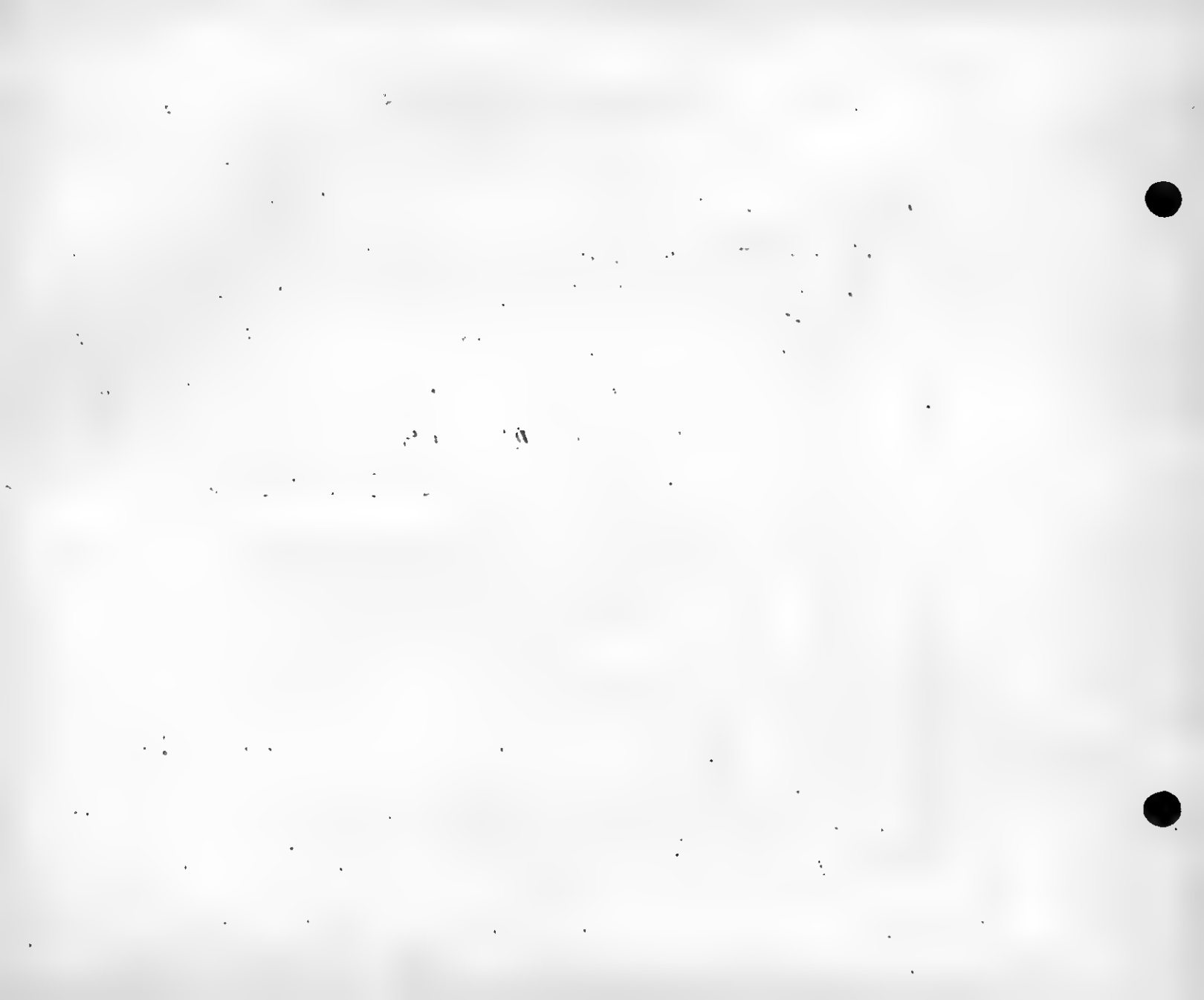


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VR 151A
30M REV. 3-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			Month	Day	Year	2b. HOUR
EVA			JANET	BOLLINGER		JAN 12 1969			5	AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
FEMALE		WHITE		OCT. 15, 1921		47 YRS.		MONTHS		DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
MARYLAND		U.S.A.				CARROLL CO.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY						
FINKSBURG ROAD		HILBER		HOUSE WIFE, STATE HIGHWAY								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
MARYLAND		CARROLL		FINKSBURG		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RD # 2				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
JOSHUA L. BARNES						MAUDE J. BARNES						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
NO			217 1814-09			WILLIAM E. BOLLINGER			SAME ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS												
411												
DUE TO, OR AS A CONSEQUENCE OF												
(b) HYPERTENSIVE CARDIOVASCULAR DIS. 4 YEARS												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION			Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from NOV 1957, to JAN 1969, that (I) (we) last saw the deceased alive on JAN 12 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYS.			22c. DATE SIGNED			
Daniel I. Welliver						<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			1-12-69			
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS									
DANIEL I. WELLIVER			19 RIDGE ROAD			WESTMINSTER MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
BURIAL		1/15/69		PROVIDENCE CEMETERY		FINKSBURG RD #2 MD.						
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
J. S. Thompson		1211 N. 1st St.		JAN 15 1969		Charles Judge						



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0065

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00651

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) HILDA NAOMI BOLLINGER			2a. DATE OF DEATH Jan Month 11 Day 19 Year 69			2b. HOUR 4 18 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JULY 1, 1900		6. AGE (In years last birthday) 68 YRS	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL CO.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) CARROLL CO. GEN HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SALES CLERK		12b. KIND OF BUSINESS OR INDUSTRY STORE	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER 139 BOND ST.		14. FATHER'S NAME First Middle Last SAMUEL BEAM		15. MOTHER'S MAIDEN NAME First Middle Last OLA RAUER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) NO		16b. SOCIAL SECURITY NO 220-34-6605		17. INFORMANT HARRY E. BOLLINGER		Address 55 CAMORE ST. WESTMINSTER, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 111X							
DUE TO, OR AS A CONSEQUENCE OF (b) Brain tumor (astrocytoma)							
DUE TO, OR AS A CONSEQUENCE OF (c) 							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 7, 1969 , to Jan 11, 1969 , that (I) (we) last saw the deceased alive on Jan 11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John S. Harshey, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/11/69	
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY M.D.				22e. ADDRESS 8 Anchor St. Westminster, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/15/69		23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH		23d. LOCATION (City or Town) (County) (State) WESTMINSTER CARROLL CO. MD.	
24. FUNERAL DIRECTOR J. S. Myers Jr., Westminster, Md.				25a. REC'D BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

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00657

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00652

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last EVA M. BONNER			2a. DATE OF DEATH Month Day Year 1 23 69			2b. HOUR 8:45 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MARCH 21, 1890		6. AGE (In years last birthday) 78 YRS	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL CO.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO. GEN. HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE-WIFE AND MGR. OF CAFETERIA		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER 19 CHASE ST.		14. FATHER'S NAME First Middle Last JOSEPH WARD		15. MOTHER'S MAIDEN NAME First Middle Last ANNIE POOLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-28-2248		17. INFORMANT MRS. BLANCHE BROTHERS		Address WESTMINSTER, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) 1 mo. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 1 mo.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) BRONCHO PNEUMONIA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/23, 1968 to 1/23, 1969 , that (I) (we) last saw the deceased alive on 1/23, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Wincent J. Brown Jr MD				22c. DATE SIGNED 1/23/69		22d. PHYSICIAN'S NAME (Type) Wincent J. Brown Jr MD	
22e. ADDRESS 2500 N. ...		22f. ADDRESS 2500 N. ...		22g. ADDRESS 2500 N. ...		22h. ADDRESS 2500 N. ...	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 1/26/69		23c. NAME OF CEMETERY OR CREMATORY PROVIDENCE CEMETERY		23d. LOCATION (City or Town) (County) (State) GAMBER, CARROLL CO. MD.	
24. FUNERAL DIRECTOR J.S. Myers Jr, Westminster, Md. 21157		25a. RECEIVED BY REGISTRAR JAN 21 1969		25b. REGISTERED BY REGISTRAR JAN 21 1969		25c. REGISTERED BY REGISTRAR JAN 21 1969	

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00659											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last Noah W. Bosley						2a. DATE OF DEATH Month Day Year 1 22 69			2b. HOUR 1 55 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 7, 1887		6. AGE (in years lost birthday) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Hospt.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Maintenance Man			12b. KIND OF BUSINESS OR INDUSTRY School		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 36 N. Main St.			
14. FATHER'S NAME First Middle Last Noah A. Bosley				15. MOTHER'S MAIDEN NAME First Middle Last Violet Harriss							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 219-12-2252		17. INFORMANT Address Mrs. William Frederick Hampstead, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC VASCULAR DISEASE</u> YEARS											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>PNEUMONITIS</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/21, 1969</u> , to <u>1/22, 1969</u> , that (I) (we) last saw the deceased alive on <u>1/22 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Vincent J. Kroening MD</u>						22c. DATE SIGNED 1/22/69		22d. PHYSICIAN'S NAME (Type) _____		22e. ADDRESS _____	
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE Jan. 24, 1969		23c. NAME OF CEMETERY OR CREMATORY Hampstead Cemetery		23d. LOCATION (City or Town) (County) (State) Hampstead Carroll Co. Md.					
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.						25a. JAN 27 1969		25b. REGISTERED			

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Harry			Stouffer	Brewer	January 25, 1969		8:30AM		
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Male	White		4-14-02			66 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Carroll County, Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville			Springfield State Hospital			Mathematician			
13a. USUALLY RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Maryland			Washington		Hagerstown	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Funkstown		
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last				
Frank R. Brewer					Minie Stouffer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
None		219-05-21467		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemorrhage 531.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Erosion of blood vessel in the floor of large DUE TO, OR AS A CONSEQUENCE OF gastric ulcer (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes Weeks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Schizophrenic reaction, paranoid type									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-23, 1948, to 1-25-1969, that (I) (we) last saw the deceased alive on 1-25-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Octavio A. Ruiz, M.D.					22c. DATE SIGNED 1-27-69				
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.					22e. ADDRESS Springfield State Hospital				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/29/69		Funkstown Cemetery		Funkstown Wash Co Md			
24. FUNERAL DIRECTOR Hagerstown Md Andrew K. Coffman Funeral Home Inc					25a. RECEIVED BY REGISTRAR JAN 30 1969		25b. REGISTRAR'S SIGNATURE [Signature]		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

00661

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00655

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Beatrice Maude Brundage			2a. DATE OF DEATH 1 Month 17 Day 69 Year			2b. HOUR 1:45 M			
3. SEX female		4. RACE white		5. DATE OF BIRTH 10/17/78		6. AGE (in years last birthday) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? England U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Rural--Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) saleslady		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY N		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2318 Cloville Avenue	
14. FATHER'S NAME First ? Middle Napper Last ?			15. MOTHER'S MAIDEN NAME First ? Middle Unknown Last ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 213-10-5190		17. INFORMANT Address Springfield Hospital records, Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Broncho Pneumonia 412.5 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with cerebral arteriosclerosis with behavioral reaction.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/29/1968 , to 1/17/1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/17/1969 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/17/69			
22d. PHYSICIAN'S NAME (Type) Glocrite G. Sagisi, M.D.				22e. ADDRESS Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/20/69		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Leonard J. Ruck Inc., Baltimore, Maryland				25a. REC'D BY REGISTRAR JAN 20 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Theckla			First nmn			Middle BURGESS			Last			2a. DATE OF DEATH Month January Day 17 Year 1969			2b HOUR 9:15 PM					
3. SEX female			4 RACE white			5. DATE OF BIRTH 8-26-91-92			6 AGE (In years lost birthday) 76 YRS.			7 UNDER YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS. HOURS MIN					
7a. BIRTHPLACE (State or foreign country) New York			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Carroll											
10 CITY OR TOWN OF DEATH Sykesville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Saleslady			12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY —			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 4902 Greenspring Avenue								
14 FATHER'S NAME Joseph			First Tasuer			Middle —			Last			15 MOTHER'S MAIDEN NAME First Victoria			Middle —			Last —		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO 217-20-8306			17 INFORMANT Records - Springfield State Hospital											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction. 4109 DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost) (b) Coronary heart disease. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CBS assoc. with cerebral arteriosclerosis with psychotic reaction.																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natlly medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 12-6-63 , 19 — , to 1-17-69 , 19 — , that (I) (we) last saw the deceased alive on 1-17-69 , 19 — , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																				
22b. SIGNATURE Mario E. Comas M.D.			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (Type) MARIO E. COMAS			22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21791																	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 1/18/69			23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial			23d. LOCATION (City or Town) (County) (State) Baltimore Baltimore Md.											
24 FUNERAL DIRECTOR Wm Cook-Brooks Inc.			ADDRESS 1050 York Rd Towson			25a. REGD. BY REGISTRAR DATE JAN 21 1969			25b. REGISTRAR'S SIGNATURE John A. Jones											



0066

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR		
EDWARD			JONES	BUTLER		Month	Day	Year	1:15 M		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male			White		10/24/81		87 YRS				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland			U.S.A.				Carroll Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hosp.			Painter					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			V		Balto. City		YES		5328 Cordelia Ave.		
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	
CHARLES			E.	BUTLER		AGNES			MARTHA	JONES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT						
no			220-07-0211		Hospital Records						
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>										days	
437.0 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterioneurosclerosis - uremia</u>										months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Generalized arteriosclerosis</u>										years	
PART 2. OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a))											
CBC assoc. with arteriosclerosis (cerebral), with psychotic reaction											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 18, 19 69</u> to <u>01/06</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>01/06</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED		
Suha Ozgun.									1/06/69		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Suha Ozgun, M.D.			Springfield State Hosp., Sykes., Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)	
Burial			Jan. 10, 1969		Cemetery Pleasant Grove, Boring, Md.		Boring, Maryland				
24. FUNERAL DIRECTOR			Eugenia F. Seitz 5209 York Rd. Balto. Md. 21212		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Seitz Funeral Home					JAN 8 1969		J. Charles Younger				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV 11-66

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> 0066 CERTIFICATE OF DEATH 0058 </div>										
1. DECEASED-NAME (Type or print) First Middle Last Bessie R Carlyle					2a. DATE OF DEATH Month Day Year 1 6 69			2b. HOUR 10a M		
3 SEX Female		4 RACE White		5 DATE OF BIRTH March 26 1902		6. AGE (in years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) N.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.				
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Waite Ave			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.			13b. COUNTY CARROLL		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Waite Ave	
14. FATHER'S NAME First Middle Last Jordan - Bunn				15. MOTHER'S MAIDEN NAME First Middle Last Katie - Williams						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO 242 144 112		17. INFORMANT Address MR Daight Carlyle Sykesville Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Recurrent Cerebral Hemorrhage 2509 DUE TO, OR AS A CONSEQUENCE OF (b) Diabetic ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 10 yrs. 15 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Flu										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Dec. 17, 1960, to Jan. 2, 1969, that (I) (we) lost saw the deceased alive on Jan. 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (dia) (did not) view the body after death.										
22b. SIGNATURE Sani Okutman					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/7/69			
22d. PHYSICIAN'S NAME (Type) Sani Okutman, M.D.					22e. ADDRESS Obrecht Rd., Sykesville, Md. 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-9-69		23c. NAME OF CEMETERY OR CREMATORY Twin oakland Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville, Carroll, Md.				
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.					25a. REC'D BY REGISTRAR JAN 10 1969		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00664										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00659									
CERTIFICATE OF DEATH																													
1 DECEASED-NAME (Type or print)					First Susan					Middle -					Last Caston					2a DATE OF DEATH 1 Month 29 Day 69 Year					2b. HOUR 1:55am				
3 SEX female					4 RACE white					5. DATE OF BIRTH 6/25/81					6 AGE (In years last birthday) 87 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS HOURS MIN				
7a BIRTHPLACE (State or foreign country) Maryland					7b CITIZEN OF WHAT COUNTRY? USA					B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Carroll Md														
10 CITY OR TOWN OF DEATH Rural--Sykesville					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife					12b. KIND OF BUSINESS OR INDUSTRY														
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.					13b COUNTY Frederick					13c CITY OR TOWN Myersville					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e STREET AND NUMBER Coxey Brown Road									
14. FATHER'S NAME First Middle Last James Quincy					15. MOTHER'S MAIDEN NAME First Middle Last Lucie Wright																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) no					16b SOCIAL SECURITY NO. (If yes give war or dates of service) unknown					17 INFORMANT Address Springfield Hospital records, Sykesville, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic brain syndrome associated with senile brain disease with behavioral reaction.</u>																													
19a DATE OF OPERATION					19b. CONDITION FOR WH CH OPERATION WAS PERFORMED					20a ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>					21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.					21f LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that <u>Dr. Bracito W. Patrício</u> (this hospital) attended the deceased from <u>10/16/1968</u> , to <u>1/29/1969</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>1/29/1969</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <u>not</u> view the body after death.																													
22b. SIGNATURE <u>Bracito W. Patrício, M.D.</u>					DEGREE M.D.					22c. DATE SIGNED <u>1/29/69</u>					22d. PHYSICIAN'S NAME (Type) <u>Bracito W. Patrício, M.D.</u>														
22e. ADDRESS <u>Springfield State Hospital</u>					22f. ADDRESS <u>Sykesville, Maryland</u>																								
23a BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE <u>2-1-1969</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>					23d. LOCATION (City or Town) (County) (State) <u>Nr. Myersville, Fred. Co. Md.</u>														
24. FUNERAL DIRECTOR <u>Paul F. Bittle</u>					ADDRESS <u>Myersville, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>JAN 31 1969</u>					25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>														

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



42-2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b. HOUR
JULIA			C.	CHIAPLAW	<input type="checkbox"/> Jan. 19, 1969					6:31 P
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		2c. DATE PRONOUNCED DEAD Month	
Female	White	No 1.23, 1904		68 YRS					Day 19, Year 1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR		
MD.		U.S.A.				Carroll		6:31 P		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Westminster		Carroll County General								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Carroll		Westminster				15 S. Treemont Rd.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
JOHN			MACKESSY		NETTIE				HALL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
NO		219-28-7377		Raymond A. Mackessy - 204 E. Darnest St						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>4</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 1/20/69		
Edward F. Wilson, M.D.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		11-23-69		Baltimore National Cemetery		Baltimore		Maryland		MD
24. FUNERAL DIRECTOR				ADDRESS		25a. CREED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Jarvis - Cunningham F.H. (Catonville, Md.)						22 1969		[Signature]		



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 006661									
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last Frieda . COHEN					Month Day Year January 10, 1969			7:10p M.	
3. SEX female		4. RACE white		5. DATE OF BIRTH		6. AGE (in years last birthday) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Office work (retired)		12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3706 Dorchester Rd.	
14. FATHER'S NAME First Middle Last Moses Cohen				15. MOTHER'S MAIDEN NAME First Middle Last Rebecca Mender					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (1 yes give war or dates of service) no				16b. SOCIAL SECURITY NO. -		17. INFORMANT MR. MEYER COHEN, 6310 GREENSPRING AVE, APT. 201			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CBS assoc. with cerebral arteriosclerosis with psychotic reaction.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 3-11-63, 19__, to 1-10-69, 19__, that (X) (we) lost saw the deceased alive on 1-10-69, 19__, and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death									
22b. SIGNATURE Arnold Melman M.D.				DEGREE ATTENDING PHYS		MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/10/69	
22d. PHYSICIAN'S NAME (Type) Arnold Melman, M.D.				22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21781					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-12-69		23c. NAME OF CEMETERY OR CREMATORY BETH EL		23d. LOCATION (City or Town) (County) (State) RANDALLSTOWN, MARYLAND			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD				DATE JAN 15 1969		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

30661

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00662

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M		
Lydia			Hood	Crawmer.	Jan 19 1969		11A		
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		
Female	white		Jan 26, 1886		82 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Carroll Co		USA-				Carroll.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Manchester, Md.		1284 Manso-Loyce Nursing Home		Nurse					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY - HITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Carroll.		Westminster		YES		29 Webster St	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
John				Crawmer.	Mary Elizabeth				McElhinney
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		220-10-5641		Nellie Lawrence, Furlong Md					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>								5 yrs	
4123 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (th s hospital) attended the deceased from 4/1, 1968, to 1/19, 1969, that (I) (we) last saw the deceased alive on 1/17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		W.H. Foard M.D. DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/19/69			
22d. PHYSICIAN'S NAME (Type)		W.H. Foard M.D.		22e. ADDRESS		254 Main St. Manchester, Md 21102			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan 22, 1969		Meadow Branch Cemetery		Westminster Carroll Md.			
24. FUNERAL DIRECTOR		25. ADDRESS		26. DATE OF REGISTRATION		27. CEMETERY			
Thomas D. Fletcher Funeral Home		254 E. Main St. Westminster Md		JAN 24 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 1-15 (9-68)
304 REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P.M.		
Rose Anna Frackman DEAVER						January 25, 1969			6:25 P.M.		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN	
female		white		9-1-79		89 YRS.					
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Carroll					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Sykesville		Springfield State Hospital		Housewife							
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland				Balto. 15				3124 Virginia Avenue			
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
John Frackman			Mary Sader								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT Address					
no			213-10-0873			Records, Springfield State Hospital					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>14124</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CBS associated with senile brain disease with psychotic reaction.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No.		City or Town		County		State	
22a. I certify that (if (this hospital) attended the deceased from <u>10-29-68</u> , 19 <u> </u> , to <u>1-25-69</u> , 19 <u> </u> , that (I) (we) lost saw the deceased alive on <u>1-25-69</u> 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Francisco J. Ceballos M.D.</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>										22c. DATE SIGNED 1-25-69	
22d. PHYSICIAN'S NAME (Type) Francisco J. Ceballos, M.D.										22e ADDRESS Springfield State Hospital Sykesville, Maryland 21774	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		1/29 JAN 69		New Cathedral Cemetery		Baltimore, Maryland					
24. FUNERAL DIRECTOR <u>J. E. Lowell Lemmon</u> ADDRESS J. E. Lowell Lemmon 4611 Park Heights Ave.						25a. REC'D BY REGISTRAR DATE JAN 30 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

VR A15
30M REV 1

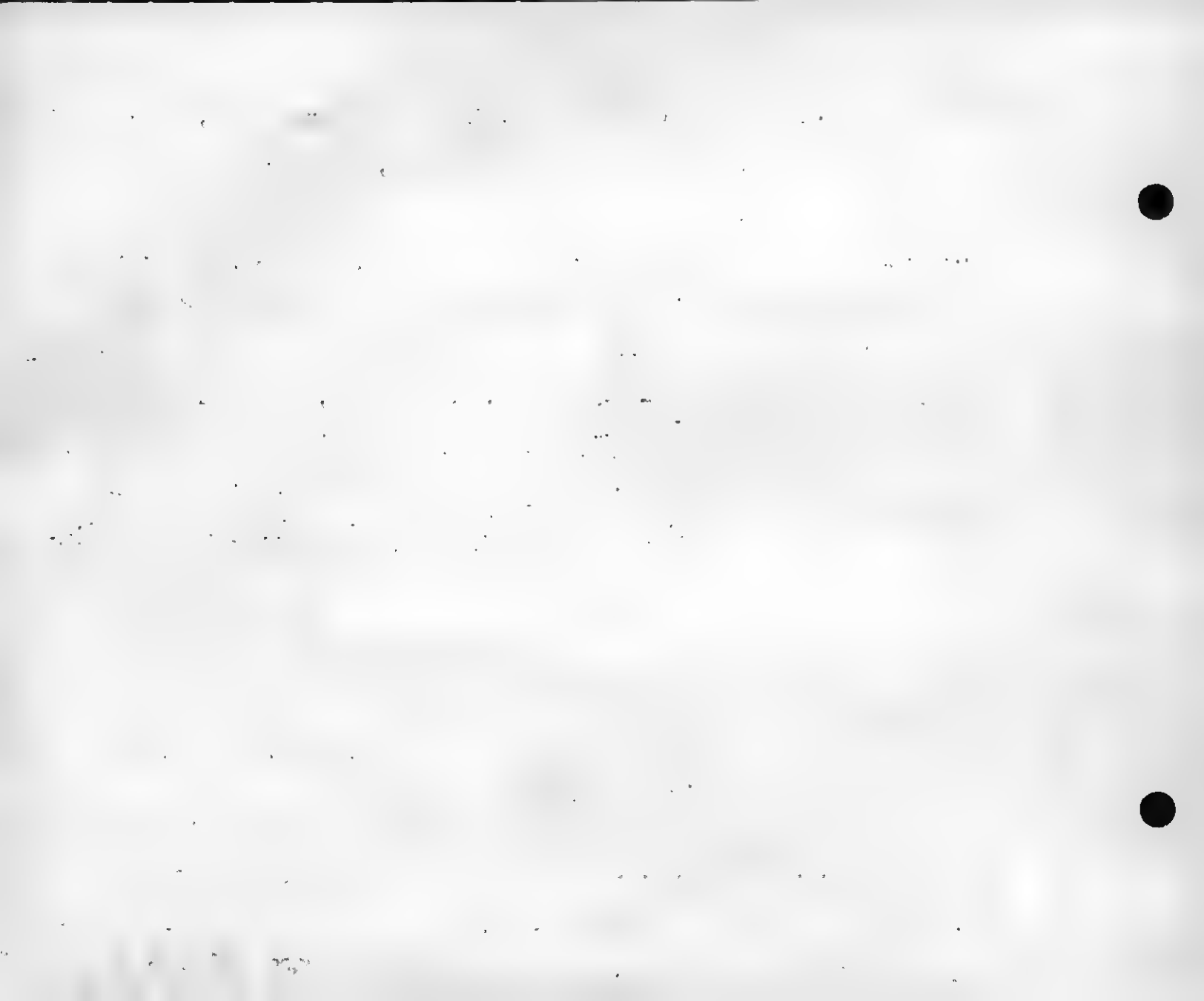
CERTIFICATE OF DEATH

00665

1. DECEASED-NAME (Type or print) Maurice Ross Fair			2a. DATE OF DEATH Month January Day 1 Year 1969			2b. HOUR 8:30 MIN A	
3 SEX Male		4. RACE White		5 DATE OF BIRTH December 1, 1876		8. AGE (In years last birthday) 92 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll	
10. CITY OR TOWN OF DEATH Taneytown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 69 George Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Linotype Operator		12b. KIND OF BUSINESS OR INDUSTRY Printing	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Taneytown		13d. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER 69 George Street		14 FATHER'S NAME First Daniel Middle Fair Last Mary		15. MOTHER'S MAIDEN NAME First Mary Middle Reindollar Last Reindollar			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. 212-03-0506		17. INFORMANT Address Mrs. M. Ross Fair, Taneytown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4104 Acute Coronary Occlusion few min DUE TO, OR AS A CONSEQUENCE OF Coronary Arteriosclerosis 20 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Dilated Arteriosclerosis 20 yrs (b) Coronary Arteriosclerosis 20 yrs DUE TO, OR AS A CONSEQUENCE OF Dilated Arteriosclerosis 20 yrs (c) Dilated Arteriosclerosis 20 yrs						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/7 , 19 64 to 1/1 , 19 69 , that (I) (we) last saw the deceased alive on 11/29 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R.S. Mc Vaughn, M.D.		22c. DATE SIGNED 2 Jan 69		22d. PHYSICIAN'S NAME (Type) R.S. Mc Vaughn, M.D.		22e. ADDRESS Taneytown, Maryland 21787	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/4/69		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Taneytown, Carroll, Maryland	
24. FUNERAL DIRECTOR C.O. Fuss & Son		25a. REC'D BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely released by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
00667- Item# 1, Film 409 1/30/69 km CERTIFICATE OF DEATH 00666												
1. DECEASED-NAME (Type or print) First Middle Last Catherine V. Fitzpatrick						2a. DATE OF DEATH Month 1 Day 1 Year 69			2b. HOUR 6:50a			
3 SEX Female		4. RACE White		5. DATE OF BIRTH 1-17-18/1895			6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Sykesville				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Nurse		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Hagerstown, Md.		
14 FATHER'S NAME First Middle Last William Fitzpatrick				15. MOTHER'S MAIDEN NAME First Middle Last Margaret Jordan								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO 215-56-3473T		17 INFORMANT Record Address Springfield State Hospital Sykesville, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency 41.4 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTINUING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 1-13-1969, to 1-18-1969, that (I) (we) last saw the deceased alive on 1-18-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Arnold Melman M.D.						DEGREE M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/18/69		
22d. PHYSICIAN'S NAME (Type) Arnold Melman, M.D.						22e. ADDRESS Springfield State Hospital Sykesville, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-26-69		23c. NAME OF CEMETERY OR CREMATORY Freedom Cemetery				23d. LOCATION (City or Town) (County) (State) Sykesville Md.				
24. FUNERAL DIRECTOR Harry W. Haight				ADDRESS Sykesville, Md.				25a. RECEIVED BY REGISTRAR JAN 28 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jones		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
JOHN EDWARD FREYMAN						Month Day Year			?
3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
MALE	WHITE	NOV. 13 1890	78 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year	9:15 P M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARR <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
CARROLL CO.		U.S.A.				CARROLL CO.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
WESTMINSTER			RD 5 DENNINGS ROAD			CARPENTER			
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
MARYLAND			CARROLL		WESTMINSTER		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RD 5 DENNINGS ROAD
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
WILLIAM EDWARD FREYMAN			MARY R. NINER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
NO			216-03-5862			WILLIAM D. FREYMAN 168 PENNA. AVE. WESTMINSTER, MD			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart Disease</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>Dissect</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dissect</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs</u>
PART 2 OTHER SIGNIF. COND TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR COND TION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. COND TION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
22a. 1 certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			22b. DATE SIGNED						
ACTUAL SIGNATURE <u>W. L. Peaches</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			2-6-69			
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			135 E. Main St. Westminister, Md.			
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County)			
BURIAL		2/4/69		DEER PARK CEMETERY		SMALLWOOD, CARROLL CO., MD			
24. FUNERAL DIRECTOR			ADDRESS			25a. FILED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. E. Myers, Jr., Westminster, Md.						FEB 4 1969		Charles Judge	

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00068

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/> 1/6/1969			2b HOUR 3:18 p.m.		
RUFUS			OSWALD			GASKINS					
3 SEX male	4 RACE negro	5 DATE OF BIRTH MAY 7 1888	6 AGE (in years last birthday) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD January 6, 1969			2d HOUR 3:18 p.m.
7a BIRTHPLACE (State or foreign country) VIRGINIA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Carroll Md					
10 CITY OR TOWN OF DEATH Sykesville		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Springfield State Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PORTER			12b KIND OF BUSINESS OR INDUSTRY MUSICAL SALES		
13a USUAL RESIDENCE (Where deceased lived, if institution address only) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1022 N. Carey St.		
14 FATHER'S NAME First Middle Last JAMES HENRY GASKINS			15 MOTHER'S MAIDEN NAME First Middle Last LOVELY ROBINSON								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIA. SECURITY NO. (If yes give war or dates of service) 218-16-2146		17 INFORMANT SARAH SMITH			17 ADDRESS 1105 ASHBURTON			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inactive Mitral Valvulitis (Rheumatic)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Emphysema</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town		State
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)			22b DATE SIGNED 1/7/69		
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b DATE 1/10/69		23c NAME OF CEMETERY OR CREMATORY WESTERN STAR CEM.			23d LOCATION (City or Town) (County) (State) CATONVILLE MD			
24 FUNERAL DIRECTOR DONALD E. GLOVER			ADDRESS 170 N. PATTERSON ST.			25a REC'D BY REGISTRAR DATE JAN 16 1969			25b REGISTRAR'S SIGNATURE Charles Judge		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000
USA
Virginia

PORTER
WASAT

218-10-2142 ARMY 2 WITH 1102 ASK FOR TON
TOWN ROBINSON
JAMES HENRY GASKINS

0067.

CERTIFICATE OF DEATH

0869

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 2 1/2 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS unknown	
3 NAME OF DECEASED (Type or print) Bernard Clark Gibson Sr.		4. DATE OF DEATH Month 1 Day 4 Year 19 69	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-91
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		11b. KIND OF BUSINESS OR INDUSTRY retired	
12. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Robert F. Gibson		15. MOTHER'S MAIDEN NAME Maude Thompson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		17. SOCIAL SECURITY NO 212-03-1719	
18. INFORMANT Records Springfield Hospital		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia 7070 DUE TO Cond. trans. if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Bedsore DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome due to Atherosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 10-21 , 19 68 , to 1-4 , 1969, that (I) (we) last saw the deceased alive on 1-4 1969, and that death occurred at 8:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Mario E. Comas		22b. DATE SIGNED 1/4/69	
22c. PHYSICIAN'S NAME (Type) Mario E. Comas M.D.		22d. ADDRESS Springfield State Hospital-Sykesville	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 7, 1969	
23c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		23d. LOCATION (City or Town) (County) (State) Frederick Frederick Md.	
24. FUNERAL DIRECTOR L. H. Etchison & Son, Frederick, Md.		25a. REC'D BY REGISTRAR Jan 8 1969	
25b. REGISTRAR'S SIGNATURE William J. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 115 1-68
30M REV 1-68

CERTIFICATE OF DEATH

00675

00670

1 DECEASED-NAME (Type or print) FRANKLIN Pool Green			2a. DATE OF DEATH Month JAN Day 22 Year 1969			2b. HOUR 3 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Nov 17, 1903		6. AGE (In years last birthday) 65 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL	
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Arthur Ave		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Auto.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Arthur Ave.							
14. FATHER'S NAME First George U. Middle Green Last Green			15. MOTHER'S MAIDEN NAME First Ida Middle - Last Kidwell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 216 100317		17. INFORMANT Address MRS. Mae Hush Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASCVD. DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR. 10 YRS 10 YRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 7, 1969 to 1-22, 1969 , that (I) (we) last saw the deceased alive on 1-22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. V. Houck, M.D. DEGREE 22d. PHYSICIANS NAME (Type) R V Houck				22c. DATE SIGNED 1-24-69		22e. ADDRESS Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-25-69		23c. NAME OF CEMETERY OR CREMATORY New Oakland		23d. LOCATION (City or Town) (County) (State) Sykesville, Md.	
24. FUNERAL DIRECTOR Harry E. Haight		24a. ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR DATE JAN 28 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00676

CERTIFICATE OF DEATH

10671

1. DECEASED-NAME (Type or print)			First GEORGE	Middle WASHINGTON	Last GREEN	2a. DATE OF DEATH Month Day Year 1 31 69			2b. HOUR A 6:30 M		
3 SEX Male		4. RACE White		5. DATE OF BIRTH 08/04/1886		6 AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Carroll County Md					
10. CITY OR TOWN OF DEATH Sykesville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Wood pattern maker			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY --		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4412 Old York Road		
14 FATHER'S NAME First Middle Last George W Green			15 MOTHER'S MAIDEN NAME First Middle Last Mary Frances Lynch								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			(If yes give war or dates of service)		16b SOCIAL SECURITY NO 218-03-7725-A		17 INFORMANT Address Springfield Hosp. Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 41211 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ✓	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CBS assoc. with cerebral arteriosclerosis with behavioral reaction											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCAT ON Street or R.F.D. No City or Town County State							
22a. I certify that I (this hospital) attended the deceased from 11/30, 1967, to 01/31, 1969, that I (we) last saw the deceased alive on 01/31/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death											
22b SIGNATURE Milton Dushman, M.D.						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/31/69			
22d. PHYSICIAN'S NAME (Type) Milton Dushman, M.D.						22e ADDRESS Springfield State Hospital					
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE 2/3/1969		23c NAME OF CEMETERY OR CREMATORY Silver Brook Cemetery			23d LOCATION (City or Town) (County) (State) Wilmington, Delaware				
24 FUNERAL DIRECTOR Eugenia I. Seitz 5209 York Road Seitz Funeral Home Baltimore, Md. 21212						25a REC'D BY REGISTRAR FEB 3 1969		25b REGISTRAR'S SIGNATURE [Signature]			

3 1

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VR A15 (4)
304 REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00672

1. DECEASED-NAME (Type or print) ELNER HALL GRESHAM			2a. DATE OF DEATH Month JANUARY Day 12 Year 1969		2b. HOUR 9:30 M
3 SEX Female	4. RACE Negro	5. DATE OF BIRTH 4-02-00		6. AGE (In years last birthday) 68 YRS.	7. UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Unk.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2201 Ettings St.
14. FATHER'S NAME First William Middle Last Hall		15. MOTHER'S MAIDEN NAME First Martha Middle Last Hall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, NO or unknown)		16b. SOCIAL SECURITY NO. 219-16-3664		17. INFORMANT GLADYS GILSTRAP Address 2108 BEYANT AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) Peripheral arterial insufficiency with gangrene of both lower legs					
PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) 4124 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis (c) Arteriosclerotic cardiovascular disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month Day Year 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State 	
22a. I certify that (I) (this hospital) attended the deceased from 12-31-68 , 19 , to 1-12-69 , 19 , that (I) (we) last saw the deceased alive on 1-12-69 , 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Paul G. Ensor, M.D.		22c. DATE SIGNED 1-12-69		22d. PHYSICIAN'S NAME (Type) Paul G. Ensor, M.D.	
22e. ADDRESS Springfield State Hospital		22f. ADDRESS Sykesville, Maryland 21784			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-17-69		23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM.	
23d. LOCATION (City or Town) BALTO.		23e. LOCATION (County) (State)			
24. FUNERAL DIRECTOR Geo. H. Nelson		24a. ADDRESS Ft. H. 1348 Calhoun St.		24b. REGISTRAR'S SIGNATURE JAN 17 1969	

MEDICAL CERTIFICATION



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
106870									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) XXXXXXXXXX First <u>Robert</u> Middle <u>Lee</u> Last <u>Griffis</u>			2a. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>69</u>			2b. HOUR <u>7:45</u> M			
3. SEX <u>MALE</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>3-15-02</u>		6. AGE (In years last birthday) <u>66</u> YRS		7. UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>	
7a. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Carroll</u>			
10. CITY OR TOWN OF DEATH <u>SYKESVILLE</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Springfield State</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Printer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Silver Spring</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Md</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>10305 Douglas Ave</u>	
14. FATHER'S NAME First <u>Richard</u> Middle <u>--</u> Last <u>Griffis</u>			15. MOTHER'S MAIDEN NAME First <u>Elizabeth</u> Middle <u>--</u> Last <u>Pearson</u>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>No</u>			
16a. SOCIAL SECURITY NO <u>212-14-5837</u>		17. INFORMANT <u>Mary A. Griffis</u>		18. ADDRESS <u>10305 Douglas Ave</u>		19. CITY OR TOWN <u>Silver Spring, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Brain Syndrome</u> <u>unrelated</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis & Psychotic Reaction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Star</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Parasitic Infection</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u>19</u> Month <u>1</u> Day <u>5</u> Year <u>1969</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) <u>Office Building</u>		21f. LOCATION Street or R.F.D. No. <u>10305 Douglas Ave</u>		City or Town <u>Silver Spring</u>		County <u>Montgomery</u> State <u>Md</u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/12</u> , 19 <u>68</u> , to <u>1/5</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Paul G. Ensor, M.D.</u>		22c. DATE SIGNED <u>1-5-69</u>		22d. PHYSICIAN'S NAME (Type) <u>Paul G. Ensor, M.D.</u>		22e. ADDRESS <u>Springfield State Hospital</u>		22f. CITY OR TOWN <u>Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-9-1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges, Maryland</u>		23e. REC'D BY REGISTRAR <u>Charles E. P. Phoy, Jr.</u>	
24. FUNERAL DIRECTOR <u>Charles E. P. Phoy, Jr.</u>		24a. ADDRESS <u>8134 Georgia Ave</u>		24b. CITY OR TOWN <u>Silver Spring, Md</u>		24c. COUNTY <u>Montgomery</u>		24d. STATE <u>Md</u>	

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00679

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00079

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ANNA MARIE HAMMETT			2a. DATE OF DEATH Jan Month 18 Day 1969 Year			2b. HOUR 10:25 AM				
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH DEC 6, 1891		6. AGE (In years last birthday) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) EALTO, ID.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL CO.				
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL GEN HOSP HOUSE 1125 HAVES INSHUL EAT		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY OPERATOR				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD #4		
14. FATHER'S NAME JAMES PETR			15. MOTHER'S MAIDEN NAME MARY ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO 213-16 0272A			17 INFORMANT MRS. MARGARET BLOOM			Address WESTMINSTER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 47 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF 2 days										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Coronary Thrombosis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan 15, 1969 to Jan 18, 1969 , that (I) (we) last saw the deceased alive on Jan 17, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John S. Harshey, M.D.					DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/18/69	
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.					22e. ADDRESS 8 Anchor St. Westminster, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/21/69		23c. NAME OF CEMETERY OR CREMATORY A RIDERS CEMETERY		23d. LOCATION (City or Town) (County) (State) WESTMINSTER RD MD				
24. FUNERAL DIRECTOR J S Myers, Jr, Westminster, Md.					ADDRESS		25a. REC'D BY REGISTRAR JAN 21 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Ruth</i> First <i>C.</i> Middle <i>Hammett</i> Last			2a DATE OF DEATH Month <i>January</i> Day <i>10</i> Year <i>1969</i>			2b HOUR <i>1230 AM</i>	
3 SEX <i>F</i>		4 RACE <i>W</i>		5 DATE OF BIRTH <i>Sept 25/92</i>		6 AGE (In years last birthday) <i>76</i> YRS	
7a BIRTHPLACE (State or foreign country) <i>Little</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Carroll Co.</i> Md.	
10 CITY OR TOWN OF DEATH <i>Frederickburg</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hamden Road</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>none</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Carroll</i>		13c CITY OR TOWN <i>Frederickburg</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First <i>Adolph</i> Middle <i>Pick</i> Last <i>Ritter</i>		15 MOTHER'S MAIDEN NAME First <i>Ida</i> Middle <i>Ritter</i> Last <i>Ritter</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b SOCIAL SECURITY NO	
17 INFORMANT <i>Southern C. Hammett</i>		Address <i>Route 3 Washington Ind., P.O. Box 86</i>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident - hemorrhage</i> 4510 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>40 hours</i> <i>9 years</i> <i>9 years</i>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from <i>1-8</i> , 1969, to <i>1-10</i> , 1969, that (I) (we) last saw the deceased alive on <i>1-9</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b SIGNATURE <i>E. M. Williams M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d PHYSICIAN'S NAME (Type)		22e ADDRESS <i>1904 Keisterstown Rd</i>		22c DATE SIGNED <i>1-10-69</i>		22f SIGNATURE <i>James J. Judge</i>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>1-13-69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Mt Olive Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Nandallstown, Path, Md.</i>	
24 FUNERAL DIRECTOR <i>Spring & Byers</i>		ADDRESS <i>8728 E. 4th Rd</i>		25a REC'D BY REGISTRAR <i>JAN 15 1969</i>		25b REGISTRAR'S SIGNATURE <i>James J. Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

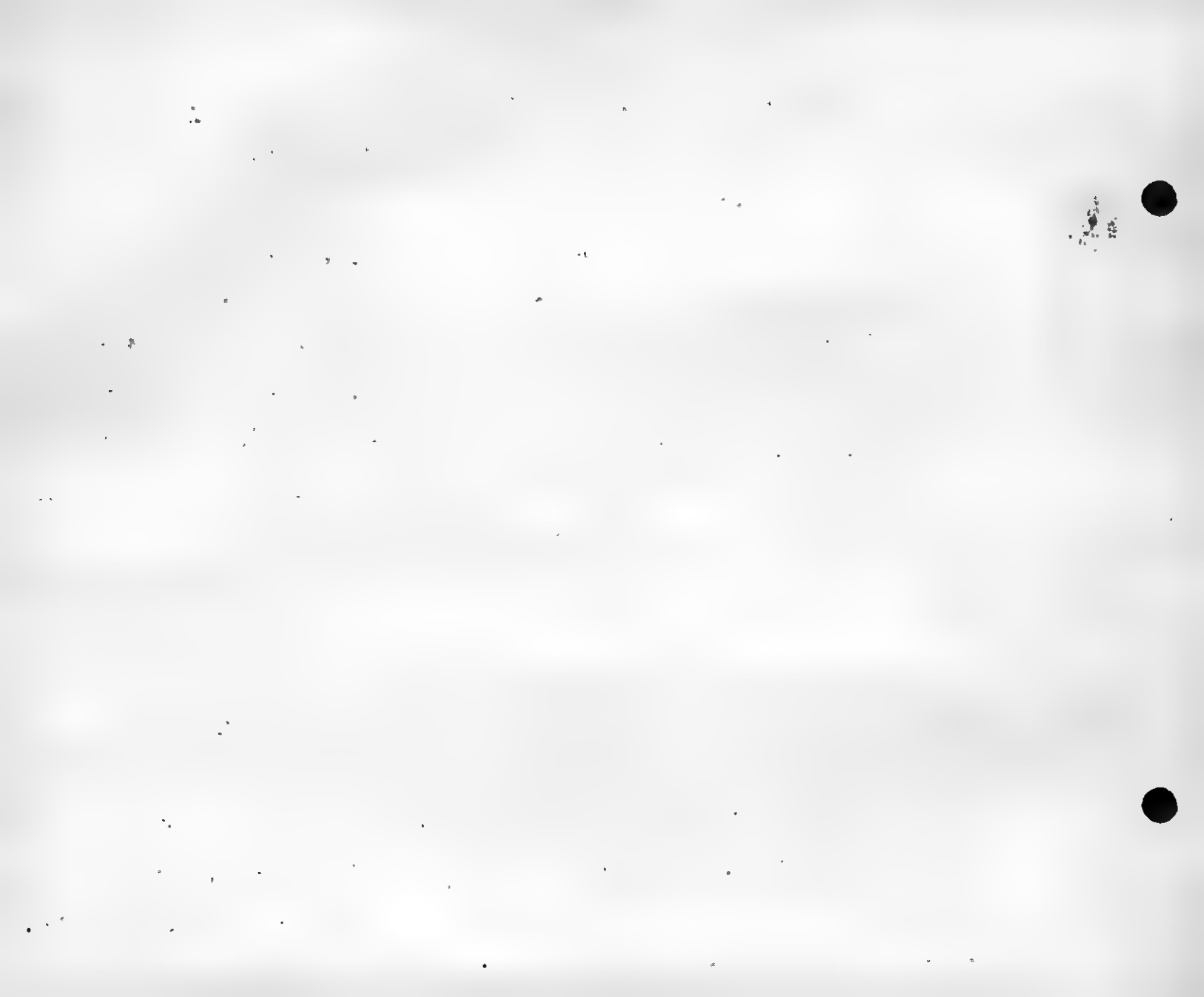
1 DECEASED-NAME (Type or print)			First CARL	Middle EGGART	Last HOMBERG	2a. DATE OF DEATH Month Day Year 01 23 69			2b. HOUR A 8:30 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 05/24/94		6 AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.					
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RES. DENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5659 W. Duane Avenue			
14. FATHER'S NAME			First CHARLES	Middle HOMBERG	15. MOTHER'S MAIDEN NAME			First ELIZABETH	Middle McKINSEY	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		(If yes give year or dates of service) 1961-1962		16b. SOCIAL SECURITY NO 367-16-9757		17. INFORMANT Address Springfield Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobarypneumonia 1621 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the lung Condit ans, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome associated with cerebral arteriosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 07/22/1968, to 01/23/1969, that (I) (we) lost saw the deceased alive on 01/23/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Suha Ozgun, M.D.						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/23/69			
22d. PHYSICIAN'S NAME (Type) Suha Ozgun						22e. ADDRESS Springfield State Hosp., Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 1/24/69		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		23d. LOCATION (City or Town) (County) (State) Balto City, Md.		23e. R. OF STATE OF DEATH JAN 27 1969			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd-21212						25a. R. OF STATE OF DEATH JAN 27 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
LILLIE		I.		HOOPER	Month 1 Day 22 Year 49		12:30 PM	
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female	White		July 3, 1891		77 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Maryland		U.S.A.				Carroll, Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Mt. Airy		R. D. 2		Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland		Carroll		Mt. Airy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R. D. 2
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
Eugene		Pickett		Verdie Harn				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT Address				
No		None		Mr. William T. Hooper Same As #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Arteriosclerotic CVD</u>								years
DUE TO, OR AS A CONSEQUENCE OF <u>Hypertension</u>								years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or RFD No. City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>								
22a. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u> </u> , to <u>11/22/49</u> , 19 <u> </u> , that (I) <u>(we)</u> lost the deceased alive on <u>1/22/49</u> , 19 <u> </u> , and that in my <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.								
22b. SIGNATURE				22c. DATE SIGNED				
<u>M. E. Robertson MD</u>				<u>11/22/49</u>				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
Dr. M. E. Robertson				<u>New Windsor, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		1/25/1969		Taylorsville		Taylorsville, Carroll, Md.		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
C. M. Waltz, Box 241, Sykesville, Md.				DATE <u>JAN 27 1969</u>		<u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD. MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Frederick F. Husselbaugh			2a. DATE OF DEATH Month Day Year JAN 6 1969		2b. HOUR 8:00 A.M.
3 SEX Male	4. RACE White	5. DATE OF BIRTH JAN. 18, 1898		6. AGE (In years lost birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.	
10. CITY OR TOWN OF DEATH MARTINISVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Arlington Rd.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) State MASON		12b. KIND OF BUSINESS OR INDUSTRY Building	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.	13b. COUNTY CARROLL	13c. CITY OR TOWN MARTINISVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Arlington Rd.	
14. FATHER'S NAME First Middle Last Frederick - Husselbaugh		15. MOTHER'S MAIDEN NAME First Middle Last MARY - Strober			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 213 C18620		17. INFORMANT Address MRS. Lola Husselbaugh MARTINISVILLE Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY INFARCTION</u> 4100 DUE TO, OR AS A CONSEQUENCE OF, <u>ASCVD.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSIVE CARDIO VASCULAR DIS.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 10 YRS. 20 YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 12-23, 1968, to 1-6, 1969, that (I) (we) last saw the deceased alive on 1-6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. H. H. M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-7-69	
22d. PHYSICIAN'S NAME (Type) R V HICK, JR.		22e. ADDRESS Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-9-69		23c. NAME OF CEMETERY OR CREMATORY Westley Freedom	
23d. LOCATION (City or Town) (County) (State) Sykesville, Md.					
24. FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR DATE 1-10-1969	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00682

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

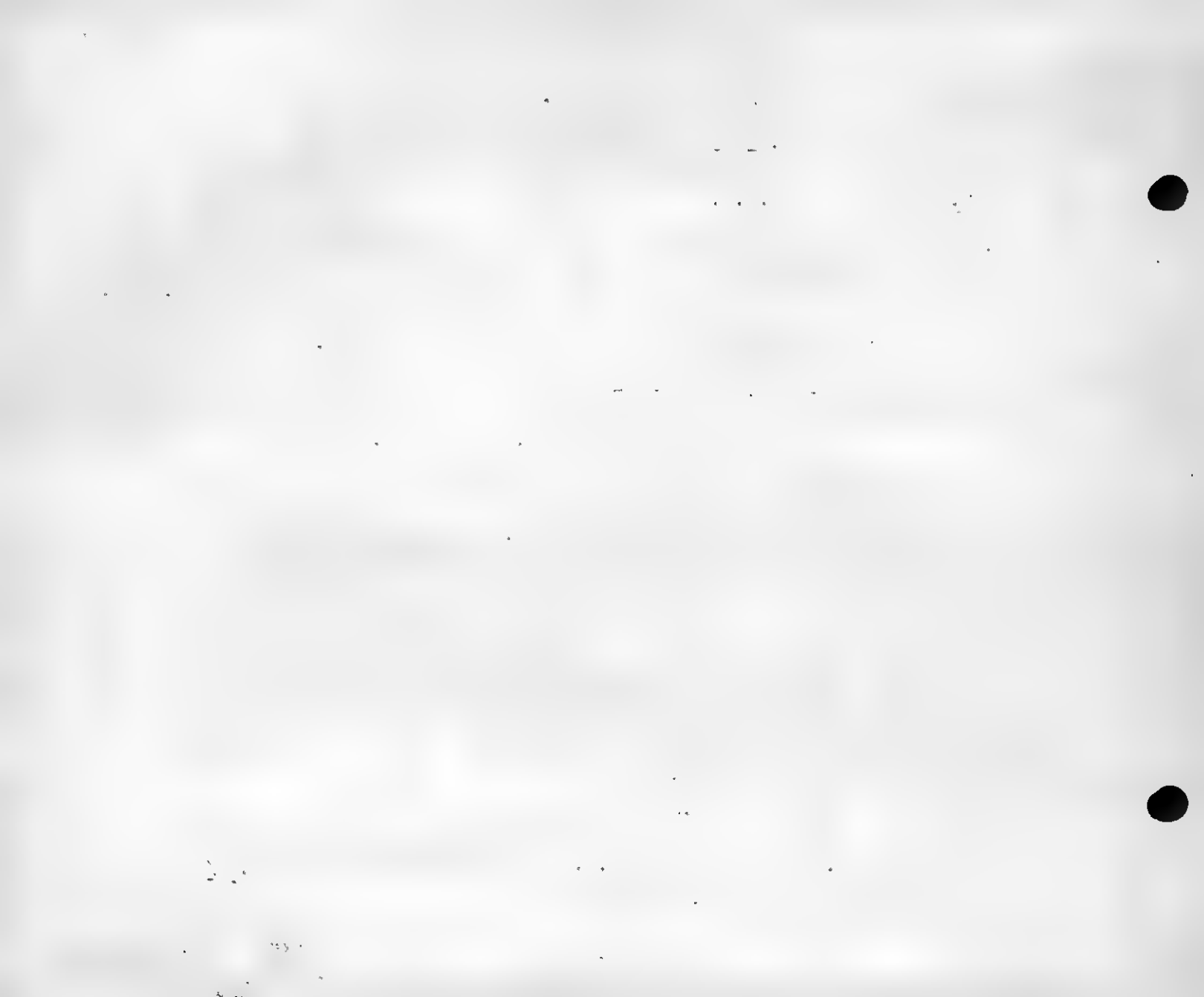
00379

1. DECEASED NAME (Type or Print) First Sophia LaVene			Middle LaVene			Last Jason			2a. DATE KNOWN OF DEATH ESTI <input type="checkbox"/> Month Day Year MATED <input checked="" type="checkbox"/> 1/18 19 69			2b. HOUR 3:00 A.M.			
3 SEX female		4 RACE negro		5 DATE OF BIRTH Oct. 30, 1968		6 AGE (in years last birthday) 2 YRS 18 MONTHS 18 DAYS		7 UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year January 18, 1969			2d. HOUR 1:00 P.M.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll						
10. CITY OR TOWN OF DEATH Sykesville				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) RD 3				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD 3					
14. FATHER'S NAME First Middle Last Unknown						15. MOTHER'S MAIDEN NAME First Middle Last Christine Jason									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO (If yes give year or dates of service) None		17. INFORMANT ADDRESS Christine Jason Same As #13.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis (DSII) 734X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Werner U. Spitz				EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				22b. DATE SIGNED 1/19/69							
23a. BURIAL, CREMATION, REMOVA. (Specify) Burial				23b. DATE 1/20/1969		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery				23d. LOCATION (City or Town) (County) (State) Carroll Co., Md.					
24. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Box 241, Sykesville, Md.						25a. REC'D BY REGISTRAR DATE JAN 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge							

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
IDM REV 1/68

<div style="display: flex; justify-content: space-between;"> 0008. MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00080 </div>																	
1. DECEASED-NAME (Type or Print)			First EMANUEL			Middle JEFFERSON			Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1 Day 4 Year 1969			2b. HOUR 4:00		
3. SEX male		4. RACE Negro		5. DATE OF BIRTH 11-06-27		6. AGE (in years last birthday) 41 YRS		7. UNDER YEAR MONTHS _____ DAYS _____		8. IF UNDER 24 HRS HOURS _____ MIN _____		2c. DATE PRONOUNCED DEAD Month 1 Day 4 Year 1969			2d. HOUR 4:30		
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Carroll					
10. CITY OR TOWN OF DEATH Sykesville				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Postal employee				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admn. State) Maryland				13b. COUNTY Carroll				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 1123 Druid Hill Ave.,			
14. FATHER'S NAME First Malichi Middle Jefferson Last						15. MOTHER'S MAIDEN NAME First Inez Middle Ware Last dec.											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16b. SOCIAL SECURITY NO 217-22-3710		17. INFORMANT ADDRESS Springfield State Hospital Records									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia, right lung. 425X DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) Status epilepticus.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year _____ P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE W. Glenn Speicher				EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 1-5-69					
23a. BURIAL, CREMATION, or other disposal (Specify) Burial				23b. DATE Jan 8 1969				23c. NAME OF CEMETERY OR CREMATORY Baltimore National				23d. LOCATION (City or Town) Baltimore Md.					
24. FUNERAL DIRECTOR Joseph L. Ruse				ADDRESS 542 Carrollton Ave.				25a. REC'D BY REGISTRAR JAN 14 1969				25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR P M	
BEATRICE HENNERITA KANE						JANUARY 16, 1969		3:05 P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		White		2-5-15-01		67 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Pennsylvania		U.S.A.				Carroll			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Springfield State Hospital		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Allegheny		Cumberland				447 Williams St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
John Harman			Eva Runk						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No		214-07-2580A		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute peritonitis and mesenteric thrombosis</u> Day									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Right iliac artery thrombosis</u> Days									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>7-26-67</u> , 19 <u> </u> , to <u>1-16-69</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>1-16-69</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Agustin del Campo MD</u>					22c. DATE SIGNED 1-17-69				
22d. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21781				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/20/69		St Mark's Episcopal Cemetery		Lewistown Penna			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Silcox-Merritt Funeral Service Cumberland, Md				DATE: 21 1969		<u>Charles J. J...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VP-1 (1-69)
30M REV 1-69

00087

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00082

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) HENRY VERNON KELLER, JR.			2a. DATE OF DEATH Month 1 Day 21 Year 69			2b. HOUR 12:15 PM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH 01/09/10		6 AGE (in years last birthday) 59 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Sykesville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Painter		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b COUNTY Balto.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER West "K" Street, 21219	
14 FATHER'S NAME First Middle Last Henry Vernon Keller, Sr.			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Runk						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO. (If yes give year or dates of service) 214-05-4128		17. INFORMANT Address Hospital records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Pyelonephritis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days mths years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CBS associated with arteriosclerosis with psychotic reaction									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan. 06, 19 69, to 01/21, 19 69, that (I) (we) lost saw the deceased alive on 01/21, 19 69, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Suha Ozgun				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 01/21/69			
22d. PHYSICIAN'S NAME (Type) Suha Ozgun, M.D.				22e. ADDRESS Springfield State Hospital, Sykes., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-13-69		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Pikesville Balto., Md.			
24. FUNERAL DIRECTOR J. Tucker & Son, Balto., Md.				25a. REC'D BY REGISTRAR DATE 12 8 1969		25b. REGISTRAR'S SIGNATURE James J. J...			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

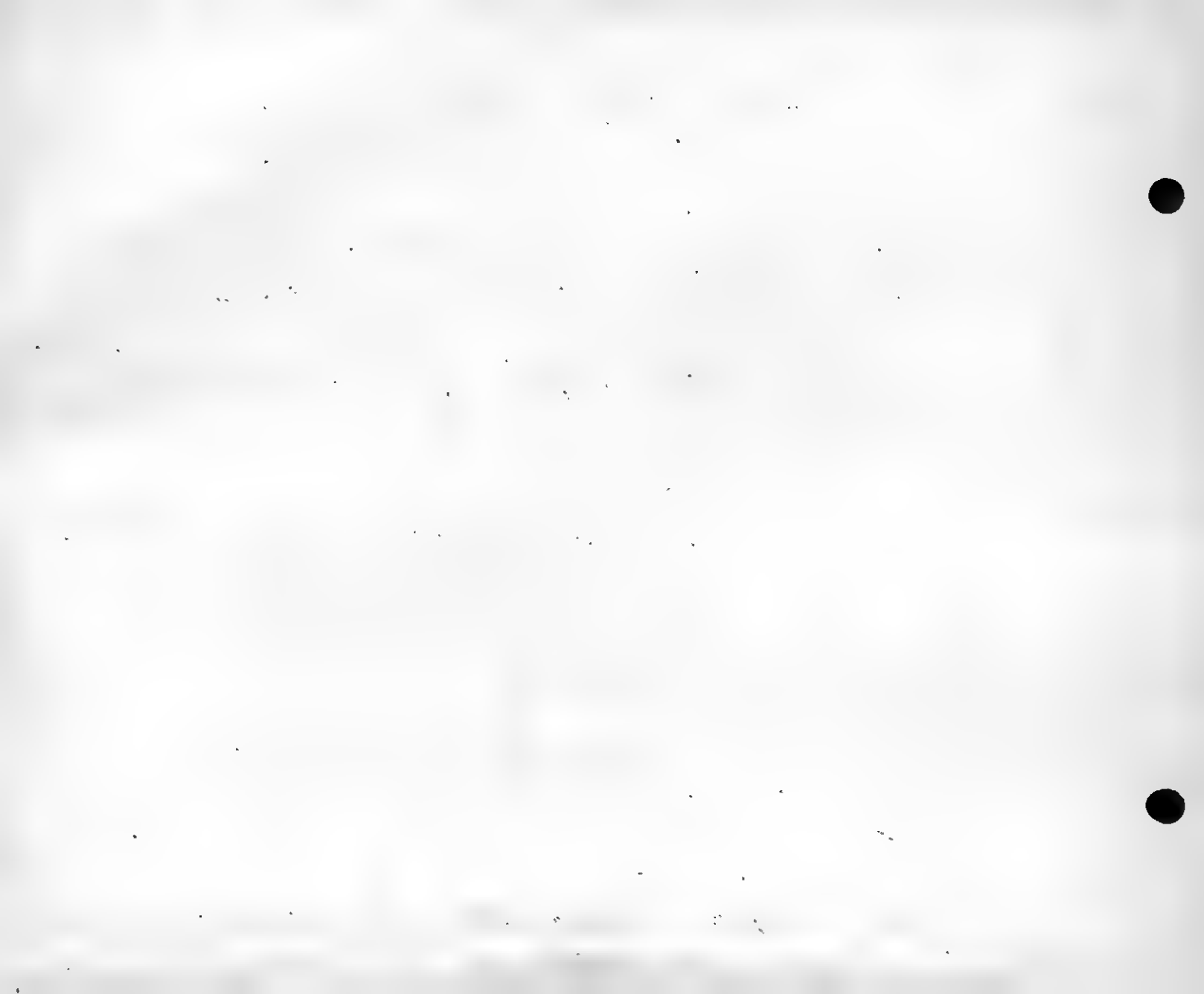
VR 45M - 1100

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <i>A-1-c-n-o</i>			First <i>MAY</i> Middle <i>Kopp</i> Last			2a. DATE OF DEATH Month <i>JAN</i> Day <i>13</i> Year <i>1969</i>		2b. HOUR <i>11:30</i> M	
3 SEX <i>female</i>		4 RACE <i>white</i>		5. DATE OF BIRTH <i>11-14-26</i>		6 AGE (in years last birthday) <i>42</i> YRS		7 UNDER 1 YEAR MONTHS <i>13</i> DAYS <i>13</i> HOURS <i>13</i> MINS <i>13</i>	
7a. BIRTHPLACE (State or foreign country) <i>York Co., Pa</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i> Md			
10. CITY OR TOWN OF DEATH <i>Lineboro</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>8 Church St</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Lineboro</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>8 Church St</i>	
14 FATHER'S NAME First <i>Arthur</i> Middle <i>C</i> Last <i>Albright</i>			15 MOTHER'S MAIDEN NAME First <i>Elise</i> Middle <i>Landis</i> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO <i>179-20-6513</i>		17 INFORMANT <i>Lenore Kopp</i>		Address <i>Lineboro Md.</i>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Adeno Carcinoma Colon</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>with metastases to liver</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>lost.</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>13 Months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>3/30</i> , 19 <i>51</i> , to <i>1/13</i> , 19 <i>69</i> , that (we) last saw the deceased alive on <i>Jan 12</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <i>W.H. Ford M.D.</i>				DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1-13-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>W.H. Ford M.D.</i>				22e. ADDRESS <i>234 Main St Manchester, Md 21102</i>					
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE <i>Jan 16 1969</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Fairview Lutheran</i>		23d. LOCATION (City or Town) (County) (State) <i>Lineboro Carroll Md</i>			
24. FUNERAL DIRECTOR <i>W.H. Ford</i>		ADDRESS <i>Olden Rock, Co.</i>		25a. REGISTRAR <i>JAN 13 1969</i>		25b. REGISTRAR'S SIGNATURE <i>W.H. Ford</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>KATHERINE LOUISE KUHN</i>						2a. DATE OF DEATH Month <i>JAN</i> Day <i>13</i> Year <i>1969</i>			2b. HOUR <i>9:25</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>18 Sept 1904</i>			6. AGE (In years last birthday) <i>64</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS HOURS <i></i> MIN. <i></i>
7a. BIRTHPLACE (State or foreign country) <i>CARROLL Co.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>CARROLL</i> Md					
10. CITY OR TOWN OF DEATH <i>WESTMINSTER</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Joseph's Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE - CLERK</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUA. RESIDENCE (Where deceased lived, if in institution, Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>CARROLL</i>		13c. CITY OR TOWN <i>WESTMINSTER</i>		13d. INSIDE CITY, IN TSP? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>62 COURT STREET</i>		
14. FATHER'S NAME First <i>Vincent</i> Middle <i>Yingling</i> Last <i></i>				15. MOTHER'S MAIDEN NAME First <i>JURAH</i> Middle <i></i> Last <i>ZENDGRAFF</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i></i>				16b. SOCIAL SECURITY NO. <i>220-18-0518</i>		17. INFORMANT <i>ANDREW KUHN</i> Address <i>DR. L. S. M. address</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1938</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) this hospital, attended the deceased from <i>April</i> , 19 <i>57</i> , to <i>present</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>2 Jan</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dean H. Griffin</i> DEGREE <i></i> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED <i>13 JAN 69</i>					
22d. PHYSICIAN'S NAME (Type) <i>DEAN H. GRIFFIN</i>						22e. ADDRESS <i>19 Ridge Rd. WESTMINSTER, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>1/16/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westminster Cemetery Westminster Md</i>			23d. LOCATION (City or Town) (County) (State) <i>Westminster Md Carroll</i>			
24. FUNERAL DIRECTOR <i>J. S. Myers, Jr., Westminster, Md</i>						25a. RECEIVED BY REGISTRAR <i>JAN 15 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00685											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
JESSIE			LOUISE LEHNAFF			Jan. 12 1969			8 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		APRIL 28, 1881		87 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
ENGLAND			U.S.A.						CARROLL CO.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
WESTMINSTER			R.F.D.#5			HOUSE-WIFE - FAMILY COMPANION					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MARYLAND			CARROLL			WESTMINSTER			R.F.D.#5		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
GEORGE CROXTON			L. GRACE E. HUSK								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
NO			120-18-2874-A			MRS PAMELA RIDGEWAY			SAME ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Pneumonia										5 days	
486X CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Generalized atherosclerosis, Psychosis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 8, 1969, to Jan 12, 1969, that (I) (we) last saw the deceased alive on Jan 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
A. Caricofe M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			1/12/69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
A. CARICOFE M.D.						UNION BRIDGE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			1/14/69			MEADOW BRANCH CEM. WESTMINSTER, MD.					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
J. S. Myers, Jr.			Westminster, Md.			JAN 15 1969			J. S. Myers, Jr.		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

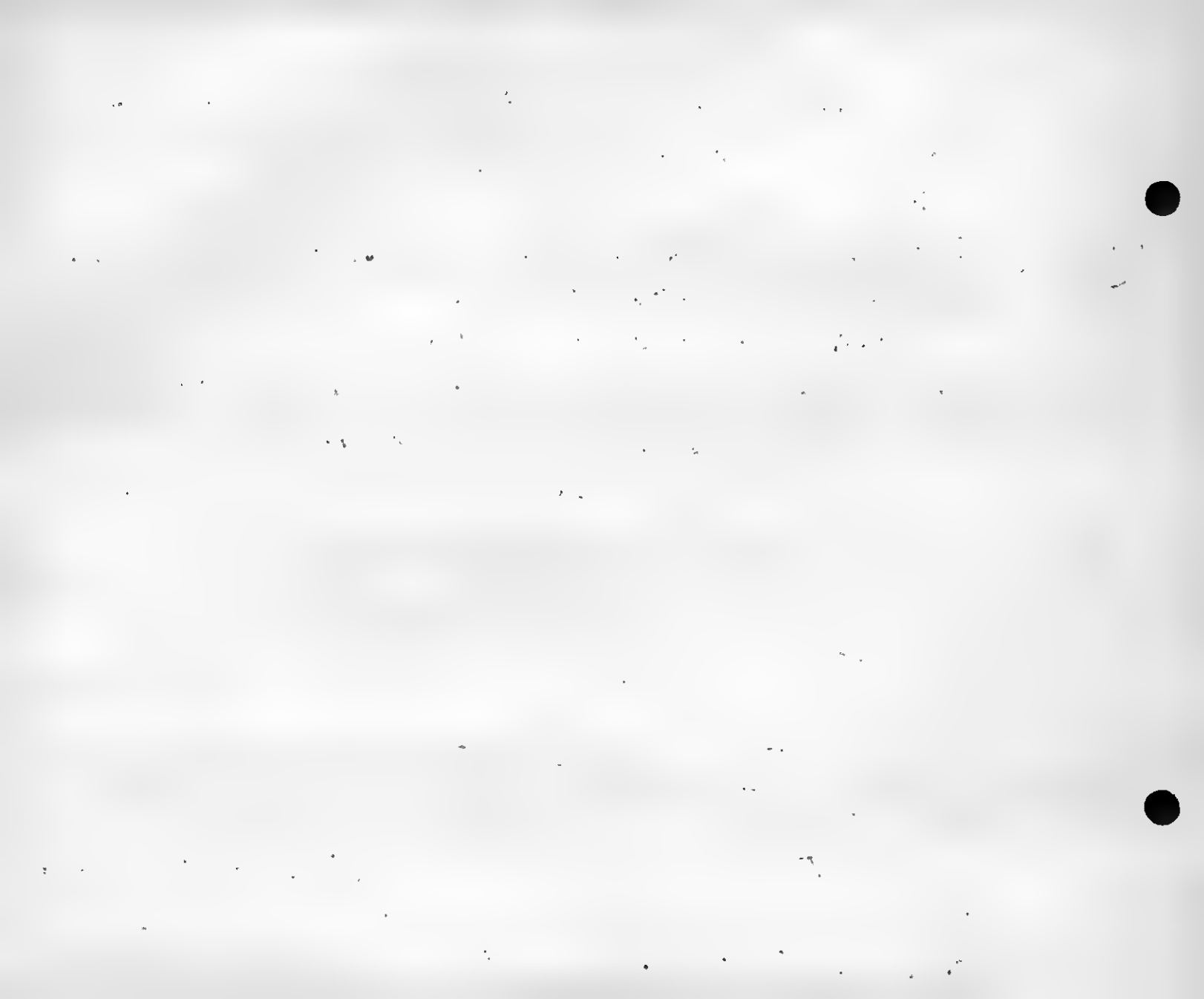
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

2009
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00686

1 DECEASED NAME (Type or print) CLARIS Ritha Ludwig			2a DATE OF DEATH Month JAN Day 27 Year 1969			2b HOUR 8P M			
3 SEX FEMALE		4 RACE White		5. DATE OF BIRTH AUG. 20, 1939		6 AGE (In years lost birthday) 29 YRS		IF UNDER YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md			
10 CITY OR TOWN OF DEATH Sykesville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) OAKLAND Road		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurses Aide		12b KIND OF BUSINESS OR INDUSTRY Hospital			
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE Md.		13b COUNTY CARROLL		13c CITY OR TOWN Sykesville		13d INSIDE CITY L.M. 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER OAKLAND Road	
14. FATHER'S NAME First Middle Last LAWRENCE ELTON Ludwig			15 MOTHER'S MAIDEN NAME First Middle Last Christina J. Ludwig						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b SOCIAL SECURITY NO —		17 INFORMANT MR LAWRENCE Ludwig - Sykesville, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomatosis 180x DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Cervix DUE TO, OR AS A CONSEQUENCE OF (c) — (Condition if any, which gave rise to immediate cause (a), stating the underlying cause last)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs. 2 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. none		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-4-59 , 19 69 , to 1-27-69 , that (I) (we) last saw the deceased alive on 1-27 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE D.D. Caples		DEGREE D. D. CAPLES, M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 1-29-69			
22d. PHYSICIAN'S NAME (Type) D. D. CAPLES, M.D.		22e ADDRESS 6 Hammer Rd Reisterstown, Md. 21136							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-30-69		23c NAME OF CEMETERY OR CREMATORY LAKE View Cemetery		23d LOCATION (City or Town) (County) (State) Sykesville Carroll Md			
24. FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sykesville, Md.		25a READ BY REGISTRAR DATE JAN 31 1969		25b REGISTRAR'S SIGNATURE Charles Judge			

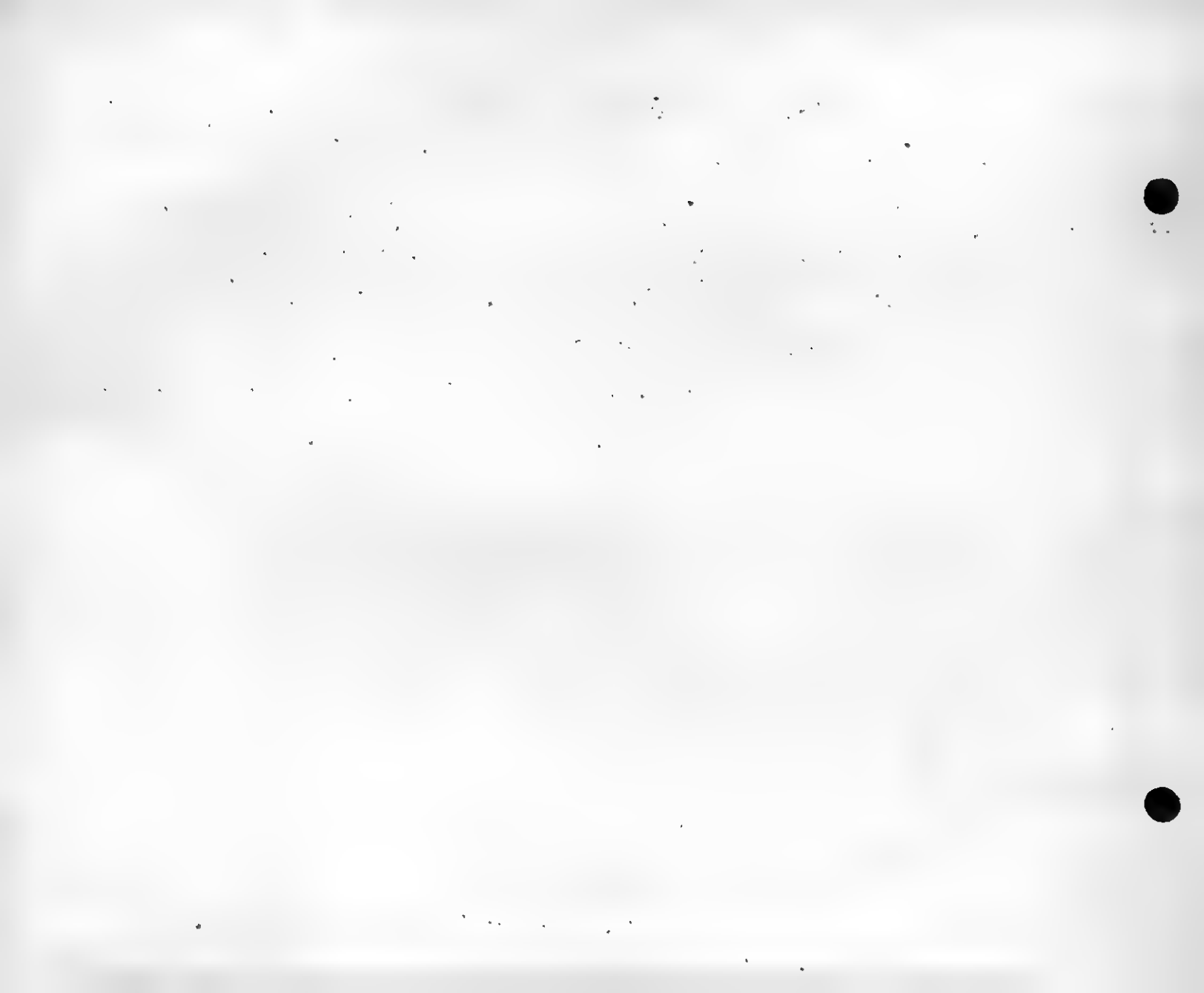


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last FRANCIS STEWART Miles						2a. DATE OF DEATH Month Day Year JANUARY 10 1969			2b. HOUR M 1		
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 5-28-1898		6. AGE (In years last birthday) 70 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Co. Md.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BIRD VIEW Rd				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Book Keeper			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md		13b. COUNTY CARROLL		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER BIRD VIEW Rd			
14. FATHER'S NAME First Middle Last SAMUEL F. Miles				15. MOTHER'S MAIDEN NAME First Middle Last VIRGINIA Waples							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 312-07-7733		17. INFORMANT Address MARY BELLE MILES - Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4210 IMMEDIATE CAUSE (a) Coronary heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary prostatic											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE G. G. G. G.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE 1-13-69		23c. NAME OF CEMETERY OR CREMATORY WOOD LAWN Cemetery		23d. LOCATION (City or Town) (County) (State) WOOD LAWN Md					
24. FUNERAL DIRECTOR ARMACOST FUNERAL Chapel - 4600 Lib. Hgts				25a. REC'D BY REGISTRAR 13 1969		25b. REGISTRAR'S SIGNATURE James Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-1-1
30A REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
CHARLES			DOLL	MITCHELL	Month 1 Day 23 Year 69		7:00 PM		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		02/16/1894		74 YRS.		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				CARROLL			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
SYKESVILLE		SPRINGFIELD STATE HOSP.		Maintenance man					
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		136		Balto.				2714 Westfield Avenue	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
JOHN			?	MITCHELL		Cora			? Doll
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
yes			1217-1219		213-05-3682-A Springfield State Hospital records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>right lung abscess</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days wks yrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CBS assoc. with cerebral arteriosclerosis without qualifying phrase									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>07/18</u> , 19 <u>68</u> , to <u>01/23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>01/23</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Cuha Ozgun, M.D.					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/23/69		
22d. PHYSICIAN'S NAME (Type) Siha Ozgun					22e ADDRESS Springfield State Hospital, Sykesville, Md.				
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		1/27/69.		Loudon Park Cemetery		Baltimore, Md.			
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214					25a REC'D BY REGISTRAR DATE JAN 24 1969		25b. REGISTRAR'S SIGNATURE William H. Jones		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00694

CERTIFICATE OF DEATH

0089

1. DECEASED-NAME (Type or print) CLAUDE WARREN MITTEN			2a. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>69</u>		2b. HOUR <u>11:57</u> M
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH SEPT. 21, 1889		6. AGE (In years last birthday) <u>79</u> YRS	IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH CARROLL COUNTY		
10. CITY OR TOWN OF DEATH WESTMINSTER	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO. GEN. HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PAPERHANGER	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE MARYLAND	13b. COUNTY CARROLL	13c. CITY OR TOWN WESTMINSTER	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 276 EAST MAIN STREET	
14. FATHER'S NAME First Middle Last WILLIAM W. MITTEN		15. MOTHER'S MAIDEN NAME First Middle Last LAURA SLONAKER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, on, or unknown) YES (If yes give war or dates of service) MEXICAN	16b. SOCIAL SECURITY NO. 217 05 5326	17. INFORMANT MRS DALE E. WEAVER		16c. 164 LIBERTY ST. WESTMINSTER, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac-arrest - Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACVD Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACVD</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>24 hr.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <u> </u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June, 1967</u> to <u>1/16</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1/16</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Philip A. Mercer</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Jan. 16, 1969
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 20, 1969	23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION (City or Town) (County) (State) Westminster, Carroll Md.	
24. FUNERAL DIRECTOR Thomas D. Fletcher Funeral Home Westminster, Md.		25. RECEIVED BY REGISTRAR 254 E. Main St.		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and interment within 72 hours after death.

VR 1-15
30M REV. 1-61

CERTIFICATE OF DEATH

20690

00090

1 DECEASED NAME (Type or print) Charles Aloysius MURK			2a DATE OF DEATH Month JAN Day 25 Year 1969		2b HOUR 8A M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MAY 2-1881		6 AGE (In years last birthday) 87 YRS.	F UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) Maryland	7b CIT ZEN OF WHAT COUNTRY? USA	8 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Cornwall Md		
10 CITY OR TOWN OF DEATH Manchester	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Long View Nursing Home 1284 Main St	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Fireman	12b KIND OF BUSINESS OR INDUSTRY Hardware		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD	13b COUNTY Cornwall	13c CITY OR TOWN Manchester	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER Rural RFD 1	
14 FATHER'S NAME First John Middle Mark Last Mark	15 MOTHER'S MAIDEN NAME First MARY Middle Blum Last Blum				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)	16b SOC. A. SECURITY NO. 220-30-273	17 INFORMANT John P. Pierce Address Manchester, Md.			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia! 185X DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) Adenocarcinoma prostate with metastases DUE TO, OR AS A CONSEQUENCE OF (c) metastases					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 3 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from June , 1957, to Jan 25 , 1969, that (I) (we) last saw the deceased alive on Jan 24 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (a) (did not) view the body after death					
22b SIGNATURE W. H. Ford M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c DATE SIGNED 1-25-69	
22d. PHYSICIAN'S NAME (Type) W. H. Ford MD		22e ADDRESS Manchester, Md 21102			
23a BURIAL, CREMATION, or other disposition Burial	23b DATE Jan. 28, 1969	23c NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		23d LOCATION (City or Town) (County) (State) Pikesville, Md.	
24 FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.			25a RECEIVED BY REGISTRY JAN 28 1969		25b REGISTRY SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

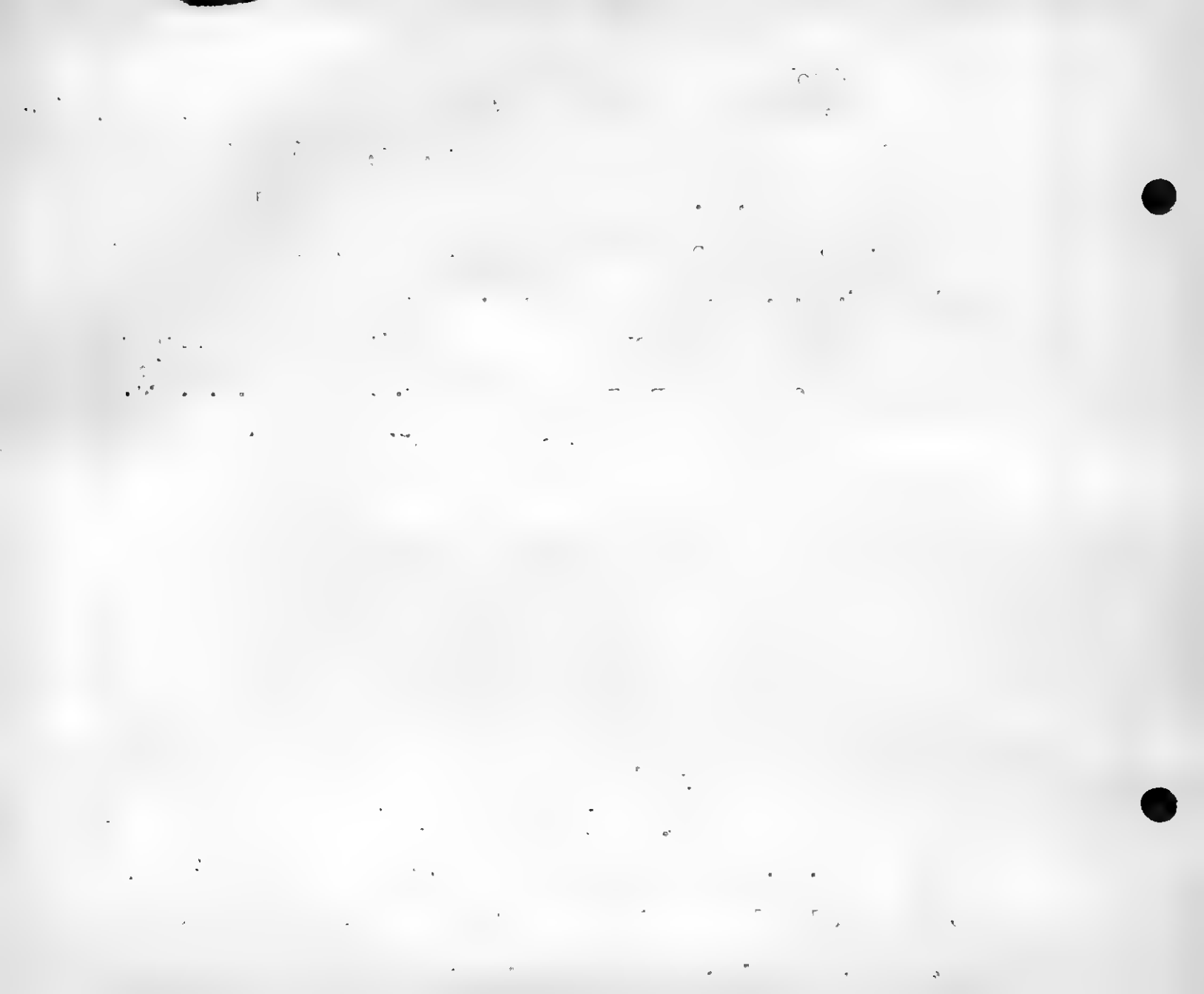
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 14141
30 MAR 1968

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

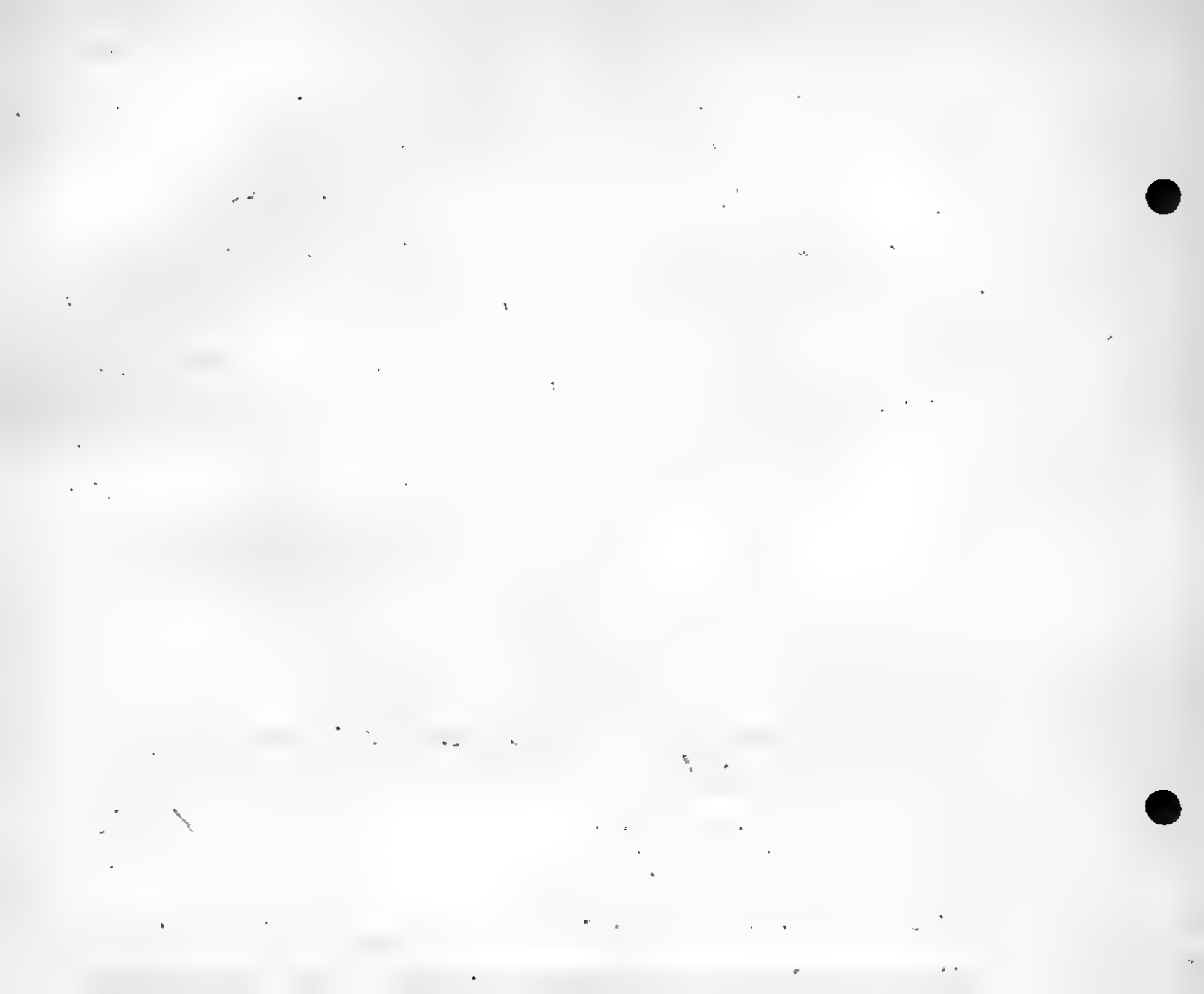
1 DECEASED-NAME (Type or print) Pheobe Phoebe		Middle Anna	Last Murray	2a. DATE OF DEATH Month Jan. Day 3 Year 1969		2b. HOUR 1:30 A M
3 SEX female	4 RACE white	5. DATE OF BIRTH Sept. 16, 1876		6. AGE (In years last birthday) 92 YRS.		IF UNDER YEAR MONTHS 00 DAYS 00 HOURS 00 MIN
7a BIRTHPLACE (State or foreign country) New York	7b CITIZEN OF WHAT COUNTRY? U. S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll		
10. CITY OR TOWN OF DEATH New Windsor		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Horton Boarding Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk		12b KIND OF BUSINESS OR INDUSTRY Store
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Rochester, N.Y.		13b. COUNTY Unknown	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER unknown		
14 FATHER'S NAME First Richard Middle McGovern Last McGovern		15. MOTHER'S MAIDEN NAME First Aliza Middle Lambert Last Lambert				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO 114-18-9579		17 INFORMANT Bethesda, Md. Richard W. Murray, U.S.N. Med. Center,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic C.V.D. 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 5/20/1967 to 1/3/1969 , that (I) (was) last saw the deceased alive on 1/3/69 19 69 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.						
22b. SIGNATURE M. E. Robertson MD				22c. DATE SIGNED 1/3/69		22d. PHYSICIAN'S NAME (Type) M. E. Robertson
22e. ADDRESS New Windsor, Md.				22f. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 1/6/1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland
24. FUNERAL DIRECTOR W. H. Hatcher & Sons				25a. REC'D BY REGISTRAR JAN 6 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 10 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) First Middle Last ALVA William Nelson						2a DATE OF DEATH Month Day Year JAN 2 1969			2b HOUR 1:30 PM		
3 SEX MALE		4 RACE White		5 DATE OF BIRTH NOV 26 - 1911		6 AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Kentucky		7b CITIZEN OF WHAT COUNTRY? USA -		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md					
10 CITY OR TOWN OF DEATH Hampstead		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2-7 Upper Beekesville Rd. Hampstead, Md.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer (Factory)		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Carroll		13c CITY OR TOWN Hampstead		13d INSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 217 Upper Beekesville Rd			
14 FATHER'S NAME First Middle Last Wm Nelson				15 MOTHER'S MAIDEN NAME First Middle Last Emma							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO. 480-01-3419		17 INFORMANT Mrs Alva Nelson address 217 Upper Beekesville Rd Hampstead, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Emphysema										5 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Bronchitis										5 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (1) (this hospital) attended the deceased from June 1955 , to Jan 2 1969 , that (1) (we) last saw the deceased alive on Jan 2 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b SIGNATURE W. H. Foard M.D. DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 1/2/69					
22d. PHYSICIAN'S NAME (Type) W. H. Foard MD				22e ADDRESS Manchest 05, Md 21102							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Jan. 4, 1969		23c NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		23d LOCATION (City or Town) (County) (State) Hampstead, Md.					
24. FUNERAL DIRECTOR ADDRESS Tipton - Eline Funeral Home Hampstead Md.				25a. REC'D REGISTRAR JAN 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					



CERTIFICATE OF DEATH

20693

1 DECEASED-NAME (Type or print) BANNIE G. PARKS		First Middle Last		2a. DATE OF DEATH Month JAN Day 17 Year 69		2b. HOUR 4:30 P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JAN. 5 1898		6. AGE (in years last birthday) 71 YRS.	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CHARROLL CO.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 116 WILMERT AVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY CHARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INS. DE CITY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 116 WILMERT AVE.		14. FATHER'S NAME First DAVID Middle GREEN Last GREER		15. MOTHER'S MAIDEN NAME First MARTHA Middle SERBER Last SERBER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO (If yes give year or dates of service) 228-07-6835		17. INFORMANT Address MR JIM PARKS, SAME ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) 							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10/15 , 19 68 , to 1/17 , 19 69 , that (I) (we) last saw the deceased alive on 12/19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Julius Chopko		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/19/69	
22d. PHYSICIAN'S NAME (Type) Julius Chopko M.D.		22e. ADDRESS 83 E. W. Street, Westminster, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/20/68		23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH		23d. LOCATION (City or Town) (County) (State) WESTMINSTER MD MD	
24. FUNERAL DIRECTOR X-2 Meyers & Westminister, Md		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 21 1969		25b. REGISTRAR'S SIGNATURE Alvin L. Miller	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Edward C Peregoy					JAN 18 1969		1:45 PM		
3. SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	White	3/27/84		84 YRS.		MONTHS DAYS		WOLVES MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md.			
Baltimore Co	U.S.A.			Carroll					
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Manchester, Md	Home - 1288 Main St		Producer Salesman						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LHM 157	13e. STREET AND NUMBER					
Md	Baltimore	Parkton	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	RFD 1					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Staphel				Peregoy	Sarah				Bull
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
no		216-30-3406		Mabel Turpin		Parkton 1- Md.			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) acute Heart Failure								10 hrs	
DUE TO, OR AS A CONSEQUENCE OF									
(b) Arteriosclerotic Heart Disease								5 yrs	
DUE TO OR AS A CONSEQUENCE OF metastatic Carcinoma									
(c) abdomen with ascites								1 yr	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		City or Town County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work						Street or R.F.D. No.			
22a. I certify that (I) (this hospital) attended the deceased from June 1950 to Jan 18 1969, that (I) (we) last saw the deceased alive on Jan 18 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
W.H. Foard M.D.						1-18-69			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
W.H. Foard M.D.						MANCHESTER, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/22/69		Forest Baptist Cemetery		Parkton Balto. Md.			
24 FUNERAL DIRECTOR				ADDRESS		25a. RECD BY REG STRAR		25b. REGISTRAR'S SIGNATURE	
John C. Goff				Hamstead Md		DATE JAN 21 1969		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="text-align: right;">10085</div> <div style="text-align: center;">CERTIFICATE OF DEATH</div>									
1. DECEASED-NAME (Type or print)			First JAMES			Middle ALBERT		Last QUABLES	
3. SEX Male			4. RACE Negro		5. DATE OF BIRTH 08/15/05			2a. DATE OF DEATH Month 1 Day 15 Year 69	
7a. BIRTHPLACE (State or foreign country) Maine			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL COUNTY		2b. HOUR a 11:00 M
10. CITY OR TOWN OF DEATH Cykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 514 Robert Street		
14. FATHER'S NAME First Middle Last HARRY QUABLES			15. MOTHER'S MAIDEN NAME First Middle Last JDA ???						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO 218-05-5272		17. INFORMANT Address Springfield State Hospital Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple decubiti</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) (Pick's Disease) CBC assoc. with diagnosis of unknown or uncertain causes with psychotic reaction									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>07/11/65</u> to <u>01/15/69</u> , that (he) (we) last saw the deceased alive on <u>01/15/69</u> , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Suha Ozgun, M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/15/69	
22d. PHYSICIAN'S NAME (Type) Suha Ozgun.						22e. ADDRESS			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial			23b. DATE 1-18-69		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. PK		23d. LOCATION (City or Town) (County) (State) Arbutus, Md.		
24. FUNERAL DIRECTOR Kelson Funeral Home 1388 N. Calhoun St						25a. REC'D BY REGISTRAR DATE JAN 17 1969		25b. REGISTRAR'S SIGNATURE James J. Jones	

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
Henry Bessemer Richmond					Month 7 Day 26 Year 69			10A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR	
Male		White		11-19-90		78 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Carroll Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville		Springfield State Hosp			Garment Cutter		Clothing		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Balto. City		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		473 Notre Dame Lane	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last				
Henry H. Richmond					Ann Wright				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Yes		not known		214-01-9020		Springfield State Hosp. Records		Day	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pilataler Bronchopneumonia</u> 4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CBS associated with alcohol intoxication without qualifying phrase</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-22-68</u> , 19 <u> </u> , to <u>1-26-69</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>1-26-69</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. Antonius Glenn</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1-26-69</u>		
22d. PHYSICIAN'S NAME (Type) Antonius Glenn, M.B.					22e. ADDRESS Sykesville, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/29/1969		Baltimore National Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR: <u>Seitz 5209 York Rd. Balto. Md. 21212</u>					25a. REC'D BY REGISTRAR <u>JAN 28 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Clarence Clayton Rosier			2a. DATE OF DEATH Month 1 Day 17 Year 69			2b. HOUR 6:44 PM	
3. SEX Male		4 RACE White		5. DATE OF BIRTH May 18, 1893		6. AGE (in years last birthday) 75 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) CARROLL Co Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) laborer		12b. KIND OF BUSINESS OR INDUSTRY State Roads	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Gaither		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First George Middle - Last Rosier		15. MOTHER'S MAIDEN NAME First Harriett Middle - Last Dailey		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			
16b. SOCIAL SECURITY NO 220 186378		17. INFORMANT Address Mrs Nellie Rosier Gaither, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC CORONARY HEART DISEASE							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 4 DAYS YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1/13, 1969 to 1/17, 1969 , that (I) (we) last saw the deceased alive on 1/17, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Vincent J. Fierco				22c. DATE SIGNED 1/17/69		22d. ADDRESS Westminster, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-20-69		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial		23d. LOCATION (City or Town) (County) (State) Sykesville Md.	
24. FUNERAL DIRECTOR Harry W. Haight		25a. REC'D BY REGISTRAR JAN 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> 0070 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00798 </div> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
Adam		F.		Safrit		Month 1 Day 27 Year 69			5:16 PM		
3. SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS		8 IF UNDER 24 HRS. HOURS
Male		White		Jan. 5, 1906			63 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Faith, N.C.		U. S.				Carroll Co., Md					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		Carroll Co. Gen Hospital			Blacksmith			Electric Co			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Carroll		Westminster		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 2, Box 260A, Westminster	
14 FATHER'S NAME				15 MOTHER'S M.A.D.E.N NAME							
First Middle Last				First Middle Last							
William Lawson Safrit				Mary		Yates					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17 INFORMANT Address					
No				237-01-5918		Mrs. Safrit - same					
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) ACUTE ANTERIOR MYOCARDIAL INFARCTION 5 DAYS											
4109 DUE TO, OR AS A CONSEQUENCE OF											
(b) ATHEROSCLEROTIC CORONARY HEART DISEASE YEARS											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from 1/23, 1969, to 1/27, 1969, that (I) (we) last saw the deceased alive on 1/27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		1-29-1969		Glen Haven Memorial Pk.		Glen Burnie, A.A.Co., Md.					
24 FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
George D. Gonce, 4001 Ritchie Hwy., Baltimore						DATE FEB 3 1969		J. Charles Jones			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 15 Film 15-8 1/14/69 kk 0070										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10099																			
1 DECEASED-NAME (Type or Print) SAMUEL CHARLES WADDELL										2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1-4 Year 1969										2b HOUR 3:10 P M																			
3 SEX M		4 RACE W		5 DATE OF BIRTH JULY 22-1918		6 AGE (In years last birthday) 50 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		F UNDER 24 HRS HOURS 0 MIN 0		2c DATE PRONOUNCED DEAD Month 1 Day 4 Year 1969										2d HOUR 3:10 P M																	
7a BIRTHPLACE (State or foreign country) MARYLAND				7b CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH CARROLL										Md																	
10 CITY OR TOWN OF DEATH WESTMINSTER				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO. HOSPITAL										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) OPERATOR										12b KIND OF BUSINESS OR INDUSTRY ORCHARD															
13a USUAL RESIDENCE (Where deceased lived, if not in institution Residence before admission) STATE MARYLAND				13b. COUNTY CARROLL				13c CITY OR TOWN NEW WINDSOR				3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				3e STREET AND NUMBER RURAL																							
14 FATHER'S NAME First S Middle BENJAMIN Last WADDELL										15 MOTHER'S MAIDEN NAME First EMMA Middle RHAPIENI Last Stuller																													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO										16b SOCIAL SECURITY NO 215-10-5407										17 INFORMANT ADDRESS MARY WADDELL NEW WINDSOR MD																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed left Chest Internal Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6.5 MIN																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:(a)																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>										21b. TIME OF INJURY Month, Day Year 1-4 1969 HOUR-AM 2:30 P.M.										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Slipped & Fell from tractor																			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> OR WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) J.P. Waddell Farm										21f. LOCATION Street or R.F.D. No. Rd 1 New Windsor City or town Carroll State MD																			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE W Glenn Speicher										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b. DATE SIGNED 1-4-69																			
EXAMINER'S NAME (Type) W GLENN SPEICHER										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE JAN 7-1969										23c. NAME OF CEMETERY OR CREMATORY PIPE CREEK										23d. LOCATION (City or Town) NEW WINDSOR MD County CARROLL									
24. FUNERAL DIRECTOR DD Hartzler & Sons										ADDRESS New Windsor										25a. REC'D BY REGISTRAR JAN 7 1969										25b. REGISTRAR'S SIGNATURE J. H. Hartzler									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) LEVI TRUMAN WAGNER			2a. DATE OF DEATH JAN Month 30 Day 1969 Year			2b. HOUR 9:50 M			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH JULY 14, 1890		6. AGE (In years last birthday) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL CO. Md			
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 8 WEBSTER ST.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RESTAURANT OPERATOR, RETIRED		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND COUNTY CARROLL		13b. CITY OR TOWN WESTMINSTER		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8 WEBSTER ST.			
14. FATHER'S NAME First GEORGE W. Middle W. Last WAGNER		15. MOTHER'S MAIDEN NAME First CATHERINE Middle MAGIN Last MAGIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 220-26-5855		17. INFORMANT Address MRS LEVI T. WAGNER, ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CEREBRAL THROMBOSIS 41a4 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DIS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -4-5 DAYS -3-4 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JAN , 19 66 , to JAN , 19 69 , that (I) (we) lost saw the deceased alive on JAN 30 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Daniel I Welliver		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1-30-69.			
22d. PHYSICIAN'S NAME (Type) DANIEL I WELLIVER		22e. ADDRESS WESTMINSTER MARYLAND							
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE 2/3/69		23c. NAME OF CEMETERY OR CREMATORY KRIDERS CEMETERY WESTMINSTER MD		23d. LOCATION (City or Town) (County) (State) WESTMINSTER MD			
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.		ADDRESS		25a. REC'D BY REGISTRAR FEB 4 1969		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00700 HELEN CERTIFICATE OF DEATH 00701									
1 DECEASED NAME (Type or print) HELEN Margaret Wildisan			2a DATE OF DEATH Jan 3 1969			2b HOUR M			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH Oct 24, 1907		6 AGE (in years last birthday) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) M.D.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll			
10 CITY OR TOWN OF DEATH MARCHESTER		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Long View Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEKEEPER		12b KIND OF BUSINESS OR INDUSTRY OWN HOME			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b COUNTY CARROLL		13c CITY OR TOWN WESTMINSTER		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 112 BOND ST.	
14 FATHER'S NAME First ELLES Middle C Last WUSAONG			15 MOTHER'S MAIDEN NAME First Olivia Middle C Last WHLIN						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) NO		16b SOCIAL SECURITY NO 214-28-0381		INFORMANT PHL. WILDISAN		Address MD WESTMINSTER			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abjection melitus c. Gangrene								5-6 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) Arterio Sclerotic Heart Disease								2-3 weeks	
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Thrombosis								6 hrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Oct 19 63 CVA, Left side paralysis									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l by medical exam'n)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from June 19 64 to Jan 5, 1969 , that (I) (we) last saw the deceased alive on Jan 5, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death									
22b SIGNATURE William Speicher				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 1-5-69	
22d PHYSICIAN'S NAME (Type) W. GLENN SPEICHER				22e ADDRESS Westminster Md 21157					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE JAN 8 1969		23c NAME OF CEMETERY OR CREMATORY MEADOW BRANCH		23d LOCATION (City or Town) (County) (State) WESTMINSTER CARROLL MD			
24 FUNERAL DIRECTOR W. D. Sington		ADDRESS NEW WINDSOR		25a REC'D BY REGISTRAR JAN 9 1969		25b REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last Nellie Wilson					2a. DATE OF DEATH Month Day Year 1-25-69			2b. HOUR 12:26 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 1-18-69		6. AGE (In years last birthday) 100 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Scotland		7b. CITIZEN OF WHAT COUNTRY? Balt.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.				
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Practical Nurse		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2606 Maryland Ave.		
14. FATHER'S NAME First Middle Last J. J. Rennie					15. MOTHER'S MAIDEN NAME First Middle Last Nellie 2 Barron					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-51-6259		17. INFORMANT Address Springfield State Hospital (Records)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years		
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>8-26-25</u> , 19____, to <u>1-25-69</u> , 19____, that (I) (we) last saw the deceased alive on <u>1-25-69</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dr. Antonius Glahn, M.D.					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-25-69	
22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.					22e. ADDRESS Springfield State Hospital Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-25-69		23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville Md.				
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.					25a. REC'D BY REGISTRAR DATE JAN 28 1969		25b. REGISTRAR'S SIGNATURE J. Charles J. J.			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00708

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00708

1. DECEASED NAME (Type or Print) LUCILLE VIRGINIA WILT			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1 Day 24 Year 1969			2b. HOUR 8:12 P.M.		
3. SEX Female	4. RACE white	5. DATE OF BIRTH 1-29-16	6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 1 Day 24 Year 1969		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll		
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife/File Clerk		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN 21230	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 509 E. 35th St.	
14. FATHER'S NAME William Cullum			15. MOTHER'S MAIDEN NAME Julia Hasley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 211-30-2562		17. INFORMANT ADDRESS Records- Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary Artery Embolism 450x DUE TO, OR AS A CONSEQUENCE OF Site of origin unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Schizophrenic reaction, chronic undifferentiated type.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE W. Glenn Speicher		EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-25-69		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/28/1969		23c. NAME OF CEMETERY OR CREMATORY Southern Cemetery		23d. LOCATION (City or Town) Dublin		(County) Md
24. FUNERAL DIRECTOR Mitchell - Weddell				ADDRESS 6500 York Rd. Home		25a. REC'D BY REGISTRAR DATE JAN 30 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

10701

UNITED STATES DEPARTMENT OF AGRICULTURE

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